The code of conduct for NHS managers: Its value and application

Fisher, Barrie

The University of Durham: Faculty of Health, Medicine and the Environment

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Barrie Fisher

Student no. 000386259

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ABSTRACT OF THESIS

The Code of Conduct for NHS Managers: Its Value and Application

In October 2002, the Department of Health published a Code of Conduct for NHS Managers. The Code set out 6 key principles of managerial conduct that were intended to guide managers in their work, to regulate their practice by stating what was required of them, and to reassure the general public about standards in NHS management.

This thesis explores the history and development of codes, in so far as they relate to the Code of Conduct for NHS managers, reviews the literature and theoretical framework for the code and seeks to establish whether the Code has, in practice, met the aspirations and aims of its architects. The thesis draws on research carried out by means of semi-structured interviews with members of the Working Group set up to produce the Code and with a range of NHS managers 'in the field'. It also includes a case study carried out to review the practical use of the Code, or other values, to inform a specific decision-making process.

The analysis of the research material suggests that the Code has, for the most part, not met the stated aims and aspirations and that there are significant areas in which the process adopted for its production could have been strengthened in the light of best practice from elsewhere. It also reveals concerns about the extent to which the Code reflects the prevailing values in NHS management, particularly in the light of the changes in policy being introduced into the NHS to create a market approach.

The conclusions suggest that the forthcoming revision of the Code should herald a different approach with more emphasis on using the opportunity to foster a clearer understanding of the values that inform NHS management and to develop a Code that, either reflects these values, or is unequivocally focussed on a regulatory purpose.

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CHAPTER 1

INTRODUCTION

In October 2002 the Department of Health published a Code of Conduct for NHS Managers (2002). This followed the findings of the Kennedy Report (2001) on Children's Heart Services at Bristol Royal Infirmary, which, among other things, was critical of the lack of any codified guidance for managers on ethical issues. The Code's stated purpose was to guide NHS managers in the values that should underpin their work, to regulate their practice by stating what is required of them, and to provide reassurance to the general public about standards in NHS management. The Code set out 6 key principles of managerial conduct and was intended to be incorporated into Chief Executive and Directors' contracts of employment *'at the earliest practicable opportunity'.*

The purpose of this research is to:

- explore the aims and aspirations of those involved in producing the Code,
- compare the extent to which these are understood and shared by managers in the field,
- review how far the Code is proving to be influential in guiding the behaviour and actions of managers in practice.

Specifically I wanted to seek answers to the following questions:

- Is the Code seen by its authors and managers in the field as fundamental to the way that managers act?
- When and how is it intended to be used?
- Is it in keeping with the prevailing organisational values and priorities in the NHS as managers perceive them?
- What steps have been taken to support the introduction of the Code since its publication?

- What is the experience of managers in using and applying the Code in practice?
- Is there evidence that the aims and aspirations of the authors of the Code are being met?
- What other factors/values are seen by managers as influential in their decision-making?

My own interest in this area of research stems from my career in health services administration and management over some 35 years, including 15 years as a Chief Executive of both hospitals trusts and health authorities. Over the last decade in particular I was directly exposed to the ethical, political and financial dilemmas facing healthcare managers in an increasingly high- profile, politically-driven public service. By the time I left the NHS, managers were being held accountable for all aspects of the service delivered by their organisations and for the achievement of multiple targets set by the government. This was a far cry from the role of administrator when I joined the service, which was restricted to the oversight of administrative and support services, excluding medical, nursing and other clinical and professional services. My NHS career, therefore, spanned this shift from administration to general management and the attendant changes in the personal accountability of managers. Over the last decade I also experienced an increase in central control measures and top-down management structures and systems designed to improve accountability for delivery of national policy imperatives.

However, in parallel with this, there had also been a drive to increase the local sensitivity and accountability of NHS bodies to ensure that local service priorities and the needs of local people were being met. This often meant that, as a Chief Executive, I was faced with difficult choices, for example, around use of resources, or entitlement to new or experimental treatments, where local and national priorities were not always in balance. On reflection, I believe that my actions in such situations were governed as much by personal values and loyalties as by my understanding of the particular situation and an

appreciation of my responsibilities, and, although I like to think that, on the whole, my actions would be viewed as fair and reasonable, I also have to accept that this was a highly private and personal process.

I was also acutely aware that many of my colleagues had faced situations that were even more taxing in terms of ethical decision-making, notably in the case of Jaymee Bowen in Cambridge in 1995, known at the time as the Child B case, and that, in such cases, a great deal was seen to depend on the framework for, and the transparency of, the decision-making process. However, I questioned in my own mind whether having a clear and transparent process was all that was needed for managers to not simply be *seen* to be acting ethically but for them to *feel* that they were doing so. Many of these difficult decisions were value-based in the sense that there was no obvious right or wrong decision and there seemed little to guide managers on what were the appropriate values for them to adopt in such cases. Moreover, it would probably be accurate to say, if my experience was anything to go by, that most managers had not had any formal training or understanding in ethics or values as they might apply to their changing responsibilities.

In these circumstances the emergence of a document codifying the conduct expected of managers held particular interest for me. If the document succeeded in setting some standards that were generally seen to be acceptable and capable of adoption and provided a framework of support to managers faced with ethical dilemmas then it may well be seen as a significant contribution by managers and, ultimately, the general public. On the other hand could such a document truly codify what was expected of managers in such a highly politicised environment or would it be seen as a statement of 'motherhood and apple pie' that did not provide any real practical guidance for managers but could be invoked if breaches were suspected?

This research, therefore, focuses on the practical usefulness of the Code of Conduct to managers in their day-to-day work and the extent to which the aims and aspirations of the authors of the Code are being met. My approach

draws on my experience and knowledge of NHS management as well as my belief that an ethical approach to management is a fundamental requirement.

Following this introduction, Chapter 2 traces the history and development of codes in so far as the origins of the NHS Code of Conduct is concerned, its antecedents and the wider policy influences, and examines some of the key drivers for codification of decision-making in the form of case studies and reports of key inquiries. This section also compares the development of the Code of Conduct with the development of codes for the medical profession where codification has a longer and more established history and where some degree of harmonisation with the managers' Code might be anticipated given that doctors and managers are increasingly expected to work together in the process of healthcare decision-making.

Chapter 3 deals with the theoretical framework for the research and includes a literature review of the ethical works on healthcare decision-making and the ethical principles that authors in this field have advanced as being important. This is intended to set out my understanding of the conceptual framework for healthcare decision-making and the extent to which this has been influential in contributing to the pressure for some form of codification to provide greater consistency about how decisions are made. The section also seeks to identify the ethical principles that might be seen to have underpinned the content of the Code of Conduct.

Chapter 4 outlines the study design and methodology used, which has been based on ascertaining the original aims for the Code in the minds of those responsible for devising it and then comparing and contrasting these aims with how it is being received and applied by managers in their day-to-day decision-making. This section sets out the rationale for the research approach and for the process adopted for the interviews and case study.

Chapter 5 presents the findings from the research and explores the aims of the Code's authors and the extent to which those aims are being met in practice. The section includes the outcomes of the interviews with a range of

NHS Chief Executives and reports their views of the usefulness of the Code and the other influences that play a part in their decision-making.

Chapter 6 sets out the findings from a specific case study looking at the impact of the Code on decision-making processes in a Primary Care NHS Trust. This is intended to provide a view of how the Code was applied in a 'real life' situation where the managers were involved in making complex value judgements.

Chapter 7 consists of an analysis of the findings, the connections with the earlier chapters on the literature review and theoretical framework for codes, and my reflections on the extent to which the Code is performing a useful function in relation to the aims of its authors and its value in practice. I also consider the possible future development of the Code in the light of my findings.

Chapter 8 draws out the key themes that have emerged from the study and relates them to my experience as a former Chief Executive in the NHS. I set out some of the issues that have emerged and the overall conclusions.

CHAPTER 2

THE DEVELOPMENT OF CODES

Introduction

This chapter concentrates primarily on the history and development of codes as they relate to the NHS, for two reasons:

- Firstly, because the purpose of the study is to focus on the Code of Conduct for NHS managers, so the historical perspective needs to orientate the reader so as to provide a clear and uncluttered context for the later analysis and findings

- Secondly, because my research has shown that, although there is a longer and more in-depth history of codes in organisational life generally, much of this relates to the business world and, as such, may not be wholly relevant or directly comparable to a public service such as the NHS.

However, a brief reference to the history of business codes is included here to show both the origin and the growth of codes in that sector over the last century, and because this helps to demonstrate some common organisational motives for the introduction of codes that, at least in part, have also influenced their introduction into the NHS. The chapter goes on to detail the background to the development of professional codes in the NHS, and specifically, some of the changes and developments that lead to the Code of Conduct for NHS managers. This includes consideration of the changes of role and responsibilities of managers particularly over the last two decades of the twentieth century, and some of the key events that have contributed to the perceived demand for, and introduction of, the Code of Conduct.

My approach to researching the history and development of codes in the NHS has inevitably been informed by my previous background in NHS

management. In so far as this chapter is concerned, I have included reflections on my experience of the changes and circumstances that may have contributed to the Code and their relative place in the history of its development.

The history of business codes

The Institute of Healthcare Management (IHM), in the introduction to a draft of its Management Code (2001) in October 2001, traced the history of written corporate codes back to 1913 with the J.C. Penney Company's:

"To test our every policy, method and act in this wise: Does it square with what is right and just?"

The same document cited studies in the US and Canada to show how corporate codes had become effectively mandatory in those countries in the latter half of the twentieth century as a consequence of legislative and financial regulatory action.

Similarly in the UK, surveys by the Institute of Business Ethics have demonstrated a steady increase in the numbers of companies adopting a code of conduct, or a code of ethics which often amounted to the same thing. Of the 300 biggest companies in 1987, 18% had codes in place. By 1997 the figure for the top 500 firms had reached 57% (White, 2000). However, The IHM draft paper also pointed out that these codes tended to focus on organisational performance and compliance with legislative and financial requirements rather than governing the actions and contributions of individual employees. This is perhaps not surprising given the number of high-profile failures in the business world, such as the Enron Corporation, where failures to observe legal and financial requirements lead to disastrous results for the company. So it might be argued that the rapid growth in codes of conduct in the corporate world over the last fifty years has been driven primarily by the instincts for self-preservation and protection against legislative, financial and public relations lapses. Whilst this is entirely legitimate and, indeed, to be

expected on the part of any responsible body, the distinction between codes that focus on compliance and those that seek to govern and guide the actions of employees is worth highlighting. The Businesses for Social Responsibility (www.businessesforsocialresponsibility.com) set up as a membership organisation for businesses worldwide who are interested in carrying out their business activities in a socially responsible manner, categorised codes in the following way:

"Codes range from value-based codes to compliance-based. At the most progressive end are value-based which are not a list of 'do's and don'ts' but rather state certain principles that are at the base of what it means to be an employee of that company. Compliance codes usually only address employee conduct and are designed to protect a company from prosecution or litigation"

This definition, whilst providing a useful way of expressing the distinction between value-based and compliance codes, possibly also suggests why most corporate codes have increasingly tended to combine some stipulations that are value-based with compliance requirements. If it is true that value-based codes are seen as more *'progressive'* and include *'principles'*, then it is probable that it may be thought that they will be more attractive and acceptable to those that they seek to govern. This might be further explained by the desire on the part of those writing corporate codes to motivate employees to achieve some higher goals or vision beyond merely complying with legal and financial requirements. In this regard, Pattison (2004) has suggested that:

'It is by persons adopting and habitually conforming to certain values in the interest of pursuing certain visions or ends that they become habitual virtuous performers' (Pattison 2004, P5)

So the notion of enshrining values within a code may be thought to be a way of motivating employees to pursue certain goals. Such values often appear in the corporate world in the form of mission statements as separate documents to codes of conduct, with the codes tending to focus almost exclusively on the

regulation or compliance requirements of the organisation. However, even in those cases, the two are meant to be read together by all employees and, as such, form a sort of composite code of conduct and behaviour. At this point it is perhaps worth reflecting that corporate codes generally are written by those running corporations. As a result it might be expected that they would reflect the interests and values of the authors as well as fulfilling the obligation to shareholders and customers to run the organisation in accordance with legal and financial requirements and in an efficient manner.

In terms of the relevance of the development of corporate codes to the Code of Conduct for NHS managers, it seems that the distinction between value-based codes and compliance codes may be significant, because, whilst most corporate codes have originated as the latter, those that are seen to be more progressive increasingly incorporate value-based principles. Similarly, this brief discussion of corporate codes has highlighted the fact that it is important to consider the influences and values of those who have written the codes and those whom they are intended to govern and guide.

Professional codes in the NHS

Codes governing the work of the professions in the NHS have a longer history than those in the corporate world, in the case of doctors, dating back to the Hippocratic Oath. The profession of medicine in particular has often been seen as the epitome of what a profession means and is one of the triumvirate of medicine, the law and the clergy that have perhaps been the most powerful professions in the western world over several centuries. Similarly nursing has an accepted status as a profession and has attained a high degree of public respect and support. It, therefore, seems useful to consider, as part of this historical perspective, how these professions have developed their codes of practice and to consider how far these have influenced the development of the manager's Code of Conduct.

Arguably the way that the medical profession has developed its codes of practice in recent years has, at least in part, been as a response to wider

social changes and challenges to the status of the profession, particularly during the last half of the twentieth century. Sociologists and authors have propounded numerous theories as to the relative importance of these changes and it is not possible or necessary to explore these in detail here, but Pill *et al* (2004) outlined some of the main sociological perspectives on the nature and functioning of professions, including the medical profession. In particular they referred to the fact that, for some analysts, the key feature for understanding professions was the moral relationship of trust with their clients and wider society. This lead, as Parsons (1951) put it, to an 'implicit contract' between society and the medical profession whereby the latter was allowed autonomy in exchange for stringent self-regulation. This, however, came under threat as it became clear that the profession was perhaps not as self-regulated or altruistic as had been thought and writers such as Freidson (1970) have argued that the medical profession generally acted in its own interest to preserve and confirm a position of dominance in society and the healthcare sector. He went on to suggest that medical dominance had meant that the profession controlled both the content of medical work and the clients, other healthcare professions, and the context within which healthcare was given, including healthcare policy.

The changing social context on which these observations were based may also have been instrumental in the growing perception within the medical profession that its procedures for self-regulation were out of date and no longer enjoyed public confidence. In the UK this lead to a number of publications, designed to reassure patients and the public that the profession was still acting appropriately and deserving of their trust and confidence. These publications emanated from the profession itself via bodies such as the General Medical Council, the British Medical Association and the Royal Colleges. The General Medical Council published 'The Duties of a Doctor' (GMC, 1995) in 1995 and 'Management in Healthcare: The Role of Doctors' (GMC, 1999) in 1999 and these laid down new standards for practicing doctors. The Royal College of General Practitioners and the General Practice Committee of the General Medical Council then produced 'Good Medical Practice for General Practitioners' (Royal College of General Practitioners,

1999) in 1999 and, in an attempt to provide guidance for the practitioner, this document defined what was expected for an acceptable standard of performance against each of the agreed principles, or values, and, conversely, what would be regarded as unacceptable practice.

The profession continues to be concerned about public trust in its activities. For example, a senior official at the British Medical Association recently suggested that, in the future, codes of practice for the profession should be written with the consent and involvement of the public to address what she saw as a perceived gap between the aspirations of the codes and the way they were viewed by the public. This seemed to be based on the belief that more public involvement would help to create better understanding between doctors and their patients of their respective roles and responsibilities and that, as a result, trust between the parties would be improved. On the other hand, however, O'Neill (2002) has argued that claims about a crisis of trust are mainly evidence of an unrealistic hankering for a world in which safety and compliance are total and breaches of trust are eliminated, whereas, if we had such certainty, there would be no need for trust. She went on to suggest that, in terms of placing our trust in professions and service providers by actively engaging with them, there was little evidence to show that we were any less trusting today than we had been in the past.

In the field of nursing, too, codes have been prominent in the work of the profession's governing bodies, culminating in the publication in 1992 of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) Code of Professional Conduct (UKCC, 1992). This code has since been revised in a new edition published by the Nursing and Midwifery Council (NMC), the successor body to the UKCC, in 2002 (NMC, 2002). Its stated purpose is to:

- *'Inform the professions of the standard of professional conduct required of them in the exercise of their professional accountability and practice*

- *Inform the public, other professions and employers of the standard of professional conduct that they can expect of a registered practitioner.'*

However, as pointed out by Wainwright and Pattison (2004), despite the fact that the NMC mailed the new edition of the Code to every one of the 600,000 or so nurses on the professional register, when they were asked as part of a survey conducted by the European Council of Nursing whether they knew about it, many said they did not. Wainwright and Pattison went on to highlight that, elsewhere, Tadd (1994), writing in a nursing journal, had argued that the (then) UKCC Code did not enhance the moral climate of nursing nor did it empower nurses. However, Hussey (1996) has pointed out that there are considerable difficulties in producing a code that could achieve these objectives other than in a very general way. Despite these concerns the importance of the Code should not be underestimated because it is used to hold individual members of the profession to account and, in that respect, it has a key function in terms of the removal of the right to practice.

In summary, therefore, it may be said that codes in the medical and nursing professions differ from corporate codes, not least in that they are produced by the professions themselves, not by employing organisations, and they are designed primarily to protect the individual members of the profession rather than the corporation. This distinction may be worth highlighting in relation to the purpose and application of the Code of Conduct for NHS managers. There is a similarity between corporate and professional codes in that corporate codes are often written with the stated intention of protecting the interests of the customers, and medical and nursing professional codes usually state that the primary aim is the safety of patients and the public. Authors and commentators, though, have questioned whether in reality professional codes can ever achieve such higher aims.

My experience of the changing role of NHS managers

The history of code development for NHS managers is much more recent than either corporate or professional codes with serious debate about the need for such provision only being activated towards the end of the 1980s with publications such as Wall's *Ethics and the Health Services Manager* (Wall 1989) published in 1989, and still to this day, one of the few dedicated texts on this subject. It is perhaps important at this stage to understand how the role of the NHS manager has changed over the last two decades of the twentieth century because this, in no small part, may have influenced the groundswell of opinion about the need for a code in some form.

Since the inception of the NHS in 1948 someone, usually with the title of 'secretary' or 'governor', administered hospitals and health services, with the role, described elsewhere (Wall 2004), of maintaining good relations with the local community and ensuring the continued financial viability of their hospital. The day-to-day running of the hospital in those days tended to be in the hands of matrons. All this began to change in 1974 with the introduction of consensus management placing administrators, as they were by that time known, as an equal on a team made up of professionals; three doctors, a nurse and an accountant, or treasurer. This status was enhanced when the Griffiths Report (DHSS 1983) proposed that there should be one general manager at the top of each NHS organisation and this lead in the majority of cases to administrators being appointed to these jobs. In 1990 this status, in many people's eyes, was further elevated when the Health Services Act, introducing internal competition into the NHS by dividing the responsibility for commissioning services from that of providing services, imported from the private sector the role of chief executive. Again the managers who had come from an administrative background were appointed to the majority of these posts.

My own career in the NHS spanned much of this period, starting in the mid-1960s as an administrative trainee and ending in 2002 after fifteen years in chief executive posts. My recollections are that the change of titles seemed at the time to chime with the way the responsibilities of the post had changed and developed. The Griffiths Report, for example, highlighted in a particularly

memorable phrase that, *"if Florence Nightingale were to reappear in the NHS she would be hard pressed to know who was in charge"*. Such was thought to be the confusion that had been engendered by the consensus management era. This certainly echoed my own experience, because, whilst there were examples of the team of peers working well, this was often in spite of the lack of clarity about who was responsible for what, whereas, in many other cases, the consensus approach was a recipe for doing nothing. However, by the time we reached the 1990s, and the new era of chief executives, there was no longer any doubt about the fact that managers in such positions had assumed greater significance in the hierarchy, although some (Harrison 1992) argued that fundamentally the relative status of managers and clinicians had not altered.

Whilst accepting that this may well have been true at that time and may in relative terms still be true today, what I would contend from my own experience was *not* at issue by the time we reached the new millennium was that the role of the chief executive now encompassed formal accountability for the efficient and effective delivery of all services as well as the responsibility for the management of the organisation. This was indeed a far cry from the limited role of her/his predecessors, epitomised in many ways by the change of title from 'secretary' in the early days of the NHS to 'chief executive' today. Some may say that job titles are not important, but in this case it illustrated the quantum shift of responsibility onto the shoulders of the manager. Individual clinicians and employees still retained responsibility for the execution of their professional and contractual obligations but final accountability for the collective efforts of the organisation in all areas of its activity was now said to rest with the chief executive.

In parallel with these changes in the role of the manager in the NHS, the last two decades of the twentieth century also saw increasing public interest and concern about the standards and practice of companies and organisations, leading to a series of reports and documents that, when taken together, also provided an important part of the context for the later development of codes. The Cadbury Report in 1992 (Cadbury 1992) made recommendations about

good corporate governance in organisational life in general, and other documents followed specifically for the NHS. These included the Code of Conduct for NHS Boards (Department of Health 1994), the Code of Practice on Openness in the NHS (Department of Health 1995), and the Institute of Directors publication in 1995 of Good practice for Directors – Criteria for NHS Boards (1995). These documents laid the foundation for public accountability in the NHS in key areas such as management accountability, accountability to patients and the public, financial accountability and clinical and professional accountability.

Following the change of government in 1997, further guidance quickly followed, largely outlining the government's vision for the NHS, as in The New NHS: Modern and Dependable (Department of Health 1997), but inevitably foreshadowing further changes in the roles and responsibilities of managers to deliver the plans. Principal amongst these changes were the plans to give expanded responsibilities to those working in primary care, general practitioners and nurses in particular, and to establish new organisations to run these services under the title of Primary Care Groups and, in due course, Primary Care Trusts (PCTs), aimed, in theory, at giving local organisations more autonomy and authority for the delivery of local services. Chief Executives were to be appointed to lead these organisations and this effectively brought primary care practitioners under the control of a general manager for the first time, whilst still retaining their independent contractor status. This measure has had the effect of creating 300+ new organisations in the NHS in the last 3 - 5 years, each with their own chief executive and management team. Without entering into the debate about the merits of this change, it is beyond dispute that many of the appointees to these posts were, simply because of the sheer numbers involved, relatively inexperienced managers taking on major new responsibilities for professional service delivery that previously had been managed within a sprawling web of independent contractors and small businesses.

Whilst writing this the next reorganisation of the NHS has recently been announced with potentially radical implications for the role and responsibilities

of NHS managers. This follows an announcement from the NHS Chief Executive that the numbers of PCTs are to be cut significantly, both to reflect a further change in responsibilities and to save money on management costs. The change will also involve clear separation between the 'new' PCTs responsible for the commissioning, or funding of services, and those organisations responsible for the delivery of services, including NHS Foundation Trusts and private sector providers. The strategic tier of management will also be changed with fewer strategic bodies responsible for managing the NHS 'market'. The detailed impact of these changes on NHS management is not clear yet but there is no doubt that it will be significant.

This review of the changing role of NHS managers perhaps serves to illustrate that the role and particularly the range of responsibilities that managers can be held accountable for, has been extended significantly in recent times. In parallel the growth in numbers of NHS organisations has lead to an increase in the population of senior NHS managers. . Arguably this placed a new strain on the management community at a time when many other pressures were already evident and many would argue that this accentuated the need for guidance, and possibly even protection, for managers faced with these responsibilities.

Events leading to the demand for a Code of Conduct for NHS managers

Over a similar period through the 1990s several key events tested what had been termed by Wall (1989) as the manager's ethical responsibility, no matter what pressures there were on the system, to see that the care and treatment of patients respects the individual and the common good at the same time. .

A series of cases in the nineties brought this responsibility into sharp focus. Perhaps the most notable of these was the so-called 'Child B' case in 1995. This involved a dispute between Cambridge Health Authority and the parent of a child named Jamyee Bowen who was suffering from an incurable disease and was being treated with a form of drug therapy that, whilst not improving

her prognosis, was arguably prolonging her life and providing pain relief. The dispute arose because the Health Authority decided after taking clinical advice that the therapy should be discontinued as there was no clear evidence of benefit. The father of Jamyee sought an injunction to stop the Health Authority from implementing its decision but the Court found in favour of the Health Authority.

In terms of the relevance of this case to the debate and subsequent production of a Code of Conduct for managers, this case was significant in that it brought to public attention in an extremely graphic way the pivotal role of the manager. The chief executive of the Health Authority at the time became a public figure appearing on radio and television, both nationally and internationally, to explain and justify his Authority's decision. The public climate was hostile, believing in some quarters that the manager was the instrument of a heartless decision that betrayed much of what the NHS stood for, that is to cure illness or, at least, to relieve suffering. However, another significant aspect of the decision of the Court in finding in the Heath Authority's favour was the importance it placed on the fact that the Health Authority could demonstrate a clear, thorough and auditable process for arriving at their decision and that the decision was one that they were empowered, indeed required, to make as part of their responsibility to determine how the resources should be used in the best interests of all patients taking into account all the evidence.

I well remember the case, as I was at the time in an equivalent post at another Health Authority. Probably the most significant outcome in relation to the lessons for managers elsewhere was the importance of ensuring that such decisions were properly taken by the Health Authority boards, not managers or clinicians acting alone, and that being able to demonstrate a clear, rigorous and transparent process of decision-making would at least help to protect the manager and other individuals from personal criticism. However, I can recall at the time feeling dissatisfied with this as my feeling was that having a clear and demonstrable process was only a part of acting ethically. I know from debate with colleagues at the time that this case left little room for doubt that

there was now a high degree of personal responsibility on the manager to ensure that the Health Authority received all the appropriate advice, that the process was well designed and followed and that all factors were taken into account. Also, rightly or wrongly, the case had established the role of the manager as the public face of the Authority in the minds of the community at large.

Over a similar period managers were increasingly in the firing line in terms of personal accountability for other issues that had previously been outside their remit, such as the clinical practice of individual clinicians, as evidenced by the cases of a Gynaecologist at William Harvey Hospital in Ashford and a pathologist at Alder Hey Hospital in Liverpool. Importantly, both managers lost their jobs as a result of these failures. However, undoubtedly the most significant of these clinical investigations was the inquiry into the provision of Children's Heart Services at Bristol Royal Infirmary. This arose when it came to light that 29 possibly preventable child deaths had taken place in the unit providing heart services for children, and that the poor record of the unit in terms of mortality rates had been known, and was a serious cause of concern, to some clinicians over a period of several years. Despite these concerns being made known at the time to those in authority, no adequate steps had been taken to address the issues. The Kennedy Report (Department of Health 2001), as it became known after the chairman Sir Ian Kennedy, included a raft of recommendations, subsequently accepted and adopted by the Government, for improving working arrangements and team working between clinicians and others, including managers, to obviate the problems in communications and compounded errors that had occurred in Bristol. One of these related to the observation that managers lacked a clear code of professional practice and that this made it difficult for them to be held publicly accountable or to be seen to be dedicated to the same aims as other professionals within the service. This particular report is widely thought to have been the single most important motivating force for the Code of Conduct for NHS managers.

These cases of failures and individual disputes about entitlement to treatment, culminating with the Kennedy Report, had, in effect, highlighted another concern that had been flagged by Wall in 1989 and had gained prominence over the nineties; that of the status of managers in relation to the NHS professions that they were by now expected to lead and manage. Wall had described this in the following terms:

"Furthermore, is it not ethically wrong to allow people without a professional code of good practice to have any responsibility, however indirect, over the welfare of patients?" Wall, 1989, p3

However, these concerns go deeper, in that they reflect also suspicions within the medical profession that managers were increasingly the functionaries of the Government and, as such, preoccupied with the achievement of government targets, potentially to the detriment of the duty that doctors see as paramount, namely, the duty of care to individual patients. Also it should be said that the situation has been complicated still further by successive initiatives to involve doctors in managerial roles, motivated usually by the belief that doctors are in the best position to make decisions on behalf of patients. This has sometimes lead to painful choices that have exposed doctors to the dilemma of deciding between what is best for a patient population as opposed to what is best for an individual patient. I will return to this issue in more detail later but my purpose in including reference to this here is because I believe that it has been an important factor in the call for a code of practice, or conduct, for managers to help to establish clearer understandings with doctors about what is appropriate behaviour for managers and those involved in management decision-making. Interestingly these debates seem to have continued unabated since the publication of the Code of Conduct for managers, with the NHS Confederation, the Academy of Medical Royal Colleges and the NHS Joint Consultants Committee sponsoring initiatives to address perceived problems in working relationships between doctors and managers following a joint conference in 2003 (NHS Confederation 2003). The report of this conference included the following

statement as part of a set of principles that should govern doctor-manager relationships:

'Doctors and managers have different roles and perspectives. Both are valid and they are complementary as both are crucial to delivering high-quality patient care. There must be mutual understanding, respect and recognition of these different perspectives:

- *Doctors have a duty to consider population/resource issues*
- *Managers have a duty to consider the requirement of doctors to do the best for individual patients.*

Both need to work together to deliver care more effectively and systematically'

Returning to the period prior to the publication of the Code of Conduct, a further significant factor was the Institute of Healthcare Management's initiative in 2001 to produce a code (IHM 2001) that was intended to ensure that its members were *'exemplars of best practice and good management'*. This code had been developed over a period of two to three years through consultation with the Institute's membership and in its final form it closely followed the model set out in the Good Medical Practice for General Practitioners document published in 1999, in that it used the method of providing examples of good and bad practice against each of the agreed principles. The code was founded upon relevant existing standards, such as the "Seven Principles of Public Life" set out in the first report published by the Committee on Standards in Public Life (1995). This Committee had been set up by the Prime Minister to 'examine current concerns about standards of conduct of all holders of public office', and became known as the Nolan Committee after the name of the Chairman, Lord Nolan. The seven principles were: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership. The Institute's code also set out seven principles – Integrity, Honesty and Openness, Probity, Accountability, Respect, the Environment, and Society. Each of these was then discussed in terms of what was expected of managers and what would constitute acceptable and

unacceptable behaviour. The IHM code is still extant today and the Institute has continued to support its use through training and education for its members, and has set up a disciplinary procedure to cover breaches of the code by its members.

The role and influence of the Institute has, however, changed in parallel with the changes in the role of managers traced earlier. For example, at the time that I joined the NHS the Institute ran a range of postgraduate qualification programmes leading by examination to the award of a Diploma in Health Services Administration (later re-named Health Services Management). Whilst not being mandatory, it was highly desirable for those wishing to progress to senior management posts and formed an integral part of the Institute's postgraduate management training programme. The Institute also ran a less demanding certificate programme that was designed to enable those who had not joined the NHS as career managers but who wanted to gain management skills and knowledge to help them in their professional roles. This tended to attract those staff that had progressed within their chosen discipline, such as therapists and radiographers, to take on responsibilities for managing staff and budgets. As a result the Institute in the seventies and early eighties had a thriving membership and a strong influence on the body of people involved in shaping the training and values of NHS managers.

This began to change as government initiatives were introduced encouraging a more pluralistic approach to NHS management with, first, the drive to bring in managers from outside the NHS to inject new thinking at the start of the nineties when NHS trusts were introduced, and, second, with the aim since the mid-nineties to attract more front-line clinical staff into management. In neither case did such people see a need to obtain the Institute's qualifications, often having already attained academic status beyond that on offer through the Institute's programmes. Nor did the 'incomers' to NHS management feel that membership of the Institute offered them any advantages, in some cases seeing it as symbolic of what needed to change in NHS management if it was to be more outward looking and embrace new ideas and approaches. Perhaps as a result of these changes the Institute no longer offers bespoke

qualifications and has experienced a significant decline in membership. Indeed it has been estimated by Wall (2004) that the Institute has within its membership something like 10% of NHS managers. It could be argued, therefore, that the influence of the Institute on the population of managers is now somewhat limited.

So perhaps it can be concluded that one of the cumulative effects of the failures in service delivery was to highlight the lack of clear professional guidance for managers as to how they might be expected to act when faced with such issues or dilemmas. This culminated in the Kennedy Report and once its recommendations had been accepted by the Government, action to develop a new mandatory code was thought to be necessary, despite the existence of the code that had already been developed by the Institute of Healthcare Management. Also a factor in the pressure for a code of practice for managers was the perception amongst some doctors that managers lacked a framework of accountability for their actions, particularly when viewed against the increase in their role and responsibilities.

Summary

In summary, the background to the development and implementation of the NHS Code of Conduct for managers probably owes something to all of the above factors. The history of corporate codes, both in North America and the UK, is founded on the need for organisations to observe the law and the financial constraints placed upon companies, and similar constraints lead to the introduction of measures to improve governance of public sector activities in the UK. The change in role for managers, and their perceived 'politicisation' over the past two decades, and particularly since the early 1990s, has deepened concern about the ways in which managers fulfil their responsibilities, from inside and outside the management community. This has been enhanced by the number of serious and high-profile failures in service delivery and performance, many of which have called into question the role of the managers and what might reasonably have been expected from them. The increased activity in terms of codifying the expectations from

professionals working in the NHS has also served to draw attention to the lack of any such code for managers, most notably in the Kennedy Report referred to above.

Bubbling under this activity has been a debate about the extent to which NHS management can be seen as a profession in the accepted sense of the word. This is an issue that I will return to in depth later but suffice to say here that it should be registered as having played a part in the historical development of the Code for managers in that many of the proponents of codification are strong advocates for 'professionalising' NHS management and see the introduction of a code upon which self-regulation, training and education can be based as an essential step in that direction. This also is linked to increased diversity of backgrounds of those in NHS management and the changing role and influence of the Institute of Healthcare Management.

The Code of Conduct for NHS managers

It was against this backcloth that, following the government's acceptance of the recommendations of the Kennedy Report, the Chief Executive of the NHS commissioned the work to produce the Code of Conduct for NHS managers (Appendix 1). A working group lead by a serving Health Authority chief executive was set up and the Code was published in October 2002 (Department of Health 2002). The group was representative of most of the main management constituencies in the NHS, including the Institute of Healthcare Management (IHM), the NHS Confederation (the employer's body representing NHS trusts and health authorities), the British Association of Medical Managers(representing doctors working in management), and the Healthcare Financial Management Association. The Code formed part of a wider initiative published by the Chief Executive of the NHS under the title "Managing for Excellence" (Department of Health 2002) and was termed in that document:

"...the cornerstone of management across the service. Its purpose is to guide NHS managers in the work they do and the decisions and choices they make.

It will also reassure the public that these important decisions are being made against a background of professional standards and accountability."

The Code requires managers to observe the following six principles:

- Make the care and safety of patients their first concern and act to protect them from risk;
- Respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- Be honest and act with integrity;
- Accept responsibility for their own work and the proper performance of the people that they manage;
- Show their commitment to working as a team member by working with all their colleagues in the NHS and the wider community;
- Take responsibility for their own personal learning and development.

For many, including the managers themselves, the added significance of the Code was that it was to be built into their contracts of employment and employers were to be charged with investigating any alleged breaches '*promptly and reasonably.'* Arrangements were to be made to support such investigations by the availability of individuals employed elsewhere to carry out such investigations. The "Managing for Excellence" publication saw the Code '*aligning with professional codes for clinicians and equivalent codes of practice for all sectors of social care.'*

CHAPTER 3

THEORETICAL FRAMEWORK

Having attempted to trace the historical background to the Code of Conduct for NHS managers, this chapter explores some of the theories and concepts relating to codes, and, in general, attempts to address the following questions:

- Why, in theory, the Code of Conduct for NHS managers might have been thought to be needed?
- What sort of code might be required?
- How should such a code be formulated?
- How it might be used and applied?

The purpose of codes

Codes of conduct, or codes of ethics, abound in professional and business life. One reason for this might be the desire on the part of organisations and occupational groups for codes to reflect what they see as their specific culture and context. Therefore, in assessing the need for a code, it may be useful to understand, or at least describe, the context and culture of the organisation or group that the code might be aimed at. In the case of the Code of Conduct for NHS managers, the context for the Code was set out by the Department of Health (2002) in Managing for Excellence. This document defined the culture, organisation and managerial style that they were seeking to establish and promote. The NHS Chief Executive described the culture in the following terms:

'We are moving towards an NHS which is truly centred on the patient, which aspires to the highest clinical standards, which is engaged in and is part of its local community, which respects and supports its staff and which is open, participative and inclusive. An NHS where every patient is an individual and so is every member of staff.'

He went on to say that '*for everyone involved in management the new Code of Conduct very effectively describes the values which underpin the culture'.* This notion of the Code as a set of underpinning values is an important concept, in that it sets the tone for the purpose of the Code in this particular case.

But are such codes seen as having real value? Some of the perceived benefits of codes in the business world are thought to include increased motivation on the part of employees to act ethically and in accordance with stated values, and an increase in the organisation's sense of identity. These benefits, of themselves, might be considered sufficient motivation to have codes and, undoubtedly, have formed at least part of the background to the development of codes in the healthcare professions. However, there are those who assert that codes have little value in helping people to arrive at decisions about the ethics of their practice, and that they merely discourage practitioners from reflecting on and constructively questioning their own actions and decisions. Loughlin (2002), for example, has argued that:

'....we [do not] solve the real ethical problems generated by our practices by constructing a "professional ethic" and simply asserting that the problems are now solved. Instead we need to find ways to <u>educate</u> ourselves: we need to develop methods of reasoning and methods of coping which will equip us to deal effectively with the problems we face in real contexts.' Loughlin 2002, P6

Loughlin strongly suggests that many of the management theories around improving standards of management and quality of services are fundamentally flawed and do not stand up to reasoned criticism. He sees codes as an example of such thinking and asserts that a renewed emphasis on education and training is required to develop the sort of managers that he believes are needed. Essentially, in his mind, this entails a recognition that managers need to be educated to think for themselves about the moral issues that they might face and to be trained to handle these in ways that show the qualities that he believes to be paramount for managers as fully functioning

rational beings, such as humility and the capacity for emotional identification with others.

In short, therefore, whilst most organisations and groups embarking on the production of codes seem to see them as embodying professional values and a supportive framework for those they are aimed to govern, there are those, like Loughlin, who feel that they simply reinforce misleading and misconceived ideas. Wainwright and Pattison (2004), whilst recognising that the impetus to codify the principles and values that can be expected from members of occupational groups by their colleagues and clients is something that all such groups face at a certain stage in their development, suggest that it needs to be recognised that the real purpose of codes may be somewhat limited:

'While they [codes] may be able to set loose boundaries of discourse on the nature of values in professional practice, they cannot resolve the ambiguities of active values management facing practitioners engaged in multi-valent situations where professional judgement is required to make an adequate response.' Wainwright and Pattison, P111

So, it would seem that the value of codes can often be over-stated, but it also has to be acknowledged that the sheer volume of codes, and the fact that most significant organisations or professional groups have them, must indicate that they are seen as being of value by them to themselves and their clients.

Having established that there may be doubts as to whether codes in general have a value; it is perhaps instructive to consider the stated purpose for having a code on the part of the particular group or organisation wishing to introduce one. Hussey (1996), writing on nursing ethics and codes of professional conduct, identified seven functions for codes of conduct:

- *'guidance – in the course of professional work*

- *regulation – prescribing norms of behaviour, moral standards and values*
- *discipline – allowing transgressions to be identified and sanctions to be imposed*
- *protection- protecting the public who rely on the professional services and protecting the employers who employ professionals*
- *information – telling clients, colleagues, etc. what standards to expect, and therefore promoting trust*
- *proclamation – telling the world that a group of workers aspires to professional status*
- *negotiation – serving to justify a stance or course of action which may be in dispute'*

Hussey, 1996, P252

One might, therefore, reasonably expect that some or all of these functions might feature in the stated purpose for codes. In so far as NHS managers are concerned, it may be noted that the Institute of Healthcare Management Code (IHM 2002) which preceded the NHS Code of Conduct, included a specific section in the preamble under the heading 'Why have a Code?' Rather unhelpfully in so far as this study is concerned, it went on to say that the reason for having a code was that the majority of respondents to a survey carried out in 1999 by the Department of Further Education and Employment as part of an Ethical Management project *"were positively disposed to the idea of a voluntary code*". The preamble did go on to examine in more detail the specific case for a code for healthcare managers and concluded that, with the development of codes for doctors and nurses, "*other professions are, therefore, moving this whole agenda forward and for those who manage them it becomes unacceptable not to take this on board.*" This would seem to be one of the IHM's main reasons for having a code, in other words to put managers on a similar footing to the NHS professions that they were now responsible for managing.

Moving forward to the NHS Code of Conduct itself, the stated purpose as set out in the preamble to the published version by the NHS Chief Executive, was:

'To guide NHS managers in the work they do and the decisions and choices they make. It will also reassure the public that these important decisions are being made against a background of professional standards and accountability.'

This statement seems to incorporate three aims:

- To guide NHS managers in their work and the decisions and choices that they have to make
- To reassure the public about these decisions
- To provide a set of professional standards for managers that they can be held accountable for by others working in the NHS, partner organisations, patients and the public

The preamble goes on to emphasise the fact that this code aligns with the professional codes for clinicians and explains that clinicians and managers need to work together to *'build and take tough decisions'.* It states*; 'that is why it is so important that all managers work to the same principles as doctors, nurses and other professionals, being personally accountable through a published code'.* This clearly indicates that the practice of management should be subject to the same sort of rules and requirements as the established NHS professions and it certainly could be argued that these aims for the code meet some, if not all, of the functions outlined for professional codes by Hussey, referred to above.

However, this aim to create a code to align managers with doctors, nurses and other NHS professionals begs a fundamental question; can management in the NHS be classified as a professional practice and what do we understand by that term? Dictionary definitions of a profession tend to include

both a narrow definition often related to the characteristics of the so-called learned professions of medicine, the law and the clergy; and a broad definition relating the term to any occupation or service by which a person earns a living. This, perhaps, does not take us much farther forward in our understanding. Similarly, if we look at some of the literature about the criteria for professional status, this, also, can be very limited. Bayles (1981), for example, argued that this was threefold:

- Extensive training
- intellectual training in kind
- Training that is related to an important service

Others have tried to define professions by identifying the qualities that practitioners need to have. Bennion (1969) suggested the following:

- integrity
- independence
- impartiality
- responsibility
- competence
- discretion

It has also been suggested that a profession is partly defined and recognised by the process that it has gone through to achieve professional status. In arguing this point Edgar (2004) said that:

'It may be suggested that those occupations that have achieved the status of a profession do so, typically, only after a protracted process of negotiation. Debates within the occupation and between the occupation and a wider public will serve to hammer out a specific self-understanding of the occupation that allows it to be accepted as a profession.' Edgar, 2004, P35

He goes on to contend that this negotiated class status is fundamental to all professions.

Freidson (2001) has written extensively on professions, particularly in the healthcare field and he provided a systematic account of professions and professionalism as a way of organising work, distinguishing between professions, technical occupations and crafts to illustrate the specific characteristics of a profession in terms of knowledge, education and ideology. He believed that professions should protect their place in society by providing a *'third logic'* to the market, where the consumer dominated, and the bureaucracy, where the manager dominated. Freidson also emphasised the need for professions to exercise moral probity through fundamental principles such as honesty, courage and justice.

Another way of construing a professional practice from a philosophical viewpoint was provided by MacIntyre (1981). He distinguished a practice as an activity involving the pursuit of both internal and external goods, defining external goods as direct rewards and satisfaction for completing an activity and meeting the required standards, and internal goods as the pursuit of excellence in the activity for its own sake. The importance of this way of defining a practice, for MacIntyre, was that the achievement of the internal goods within a practice necessarily involved the application of certain virtues such as honesty, justice and courage. The presence of these moral virtues was crucial if the practitioner was to achieve the ends to which the practice was directed in society. How does this help us in determining whether, in theory, there was a need for a Code for NHS managers? Possibly, if we were to accept that NHS management came within MacIntyre's definition of a professional practice, then we could argue that a statement, or code, setting out the virtues that were necessary components of the manager's practice might be needed to make this explicit.

This, however, is not without its complications. MacIntyre uses several examples to illustrate his way of defining a practice, asserting that, for example, whilst planting turnips is not a practice farming is, and that whilst

bricklaying is not a practice architecture is. There are many definitions of management in the NHS but most seem to emphasise the manager's role in facilitating others to deliver services and taking overall responsibility for coordination of the activities within the organisation. Whilst it is possible to argue that in carrying out this role the NHS manager is motivated by factors other than the simple achievement of results and doing a good job it is at least debatable as to whether NHS management meets MacIntyre's definition of a practice, in terms of the pursuit of excellence for its own sake as an internal good.

This in many respects mirrors the differences in opinion about whether NHS management is a profession in the accepted sense of the term. Returning to the issue of what characterizes a profession, and specifically, the medical profession. Calman (1994) has suggested that the factors are:

- *'A vocation or calling that implies service to others*
- *A distinctive knowledge base that is kept up to date*
- *A set of standards and examinations*
- *A set of particular ethical principles*
- *A special relationship with those that it serves*
- *A process for self-regulation.'*

Calman, 1994,Vol 309:1140

Currently NHS management would fail this test on a number of counts; it does not have a set of standards and examinations that are recognised as a minimum requirement to practice; it does not have a process for self-regulation, albeit the Institute of Healthcare Management would point to the process that it has introduced for its members; it does not have a distinctive knowledge base that is kept up to date. It does have a set of ethical principles in the form of the Institute's code and the NHS Code of Conduct, and arguably the aforementioned omissions could be remedied if there was a motivation within the ranks of NHS managers to move in this direction. However there would still be fundamental difficulties in NHS management being seen as a

vocation or calling and perhaps to some extent as having a special relationship with those that it serves. The significance of this debate to the question as to why, in theory, a code might be needed for NHS management is that Calman's framework of characteristics of a profession stipulates the need for a particular set of ethical principles so if NHS management were to be recognised as a profession, and particularly if it wished to be seen to have professional parity with the medical profession as stated in the aims for the Code of Conduct, some sort of code would be an essential requirement.

This analysis would suggest that, whilst some parts of the management community and indeed beyond it, might aspire to professional status for managers, there is still some way to go before this is achieved. Furthermore, some commentators disagree fundamentally with the notion or aspiration that NHS managers could be regarded as professional in the same way as their clinical colleagues. Wall (2004) argued that using a strict definition of the word, health service managers are not professionals. His rationale was that the knowledge and skills required are generalised, that managers may or may not hold relevant degrees and diplomas, that they may or may not be members of the Institute of Healthcare Management (in fact the overwhelming majority are not), and that they are neither state registered nor chartered. Again this points to the difficulties in using the Code as a vehicle to place NHS managers on a similar footing to the established NHS professions.

Returning to the other stated purpose for the NHS Code, that is, to enhance the confidence of the public in the decisions of NHS managers, this referred specifically to the findings of the Kennedy Report that, in some instances, decisions had been taken that were not in the best interests of patients as individuals but rather what were thought to be in the best interests of the institution. Also in that case, as in some others referred to in Chapter 2, the decision-making process was not well communicated to those affected by it directly. There would seem to be two sets of issues here; on the one hand relating to the motivations and the priorities that should take precedence when making management decisions; and on the other the existence of clear, open and accountable processes and procedures for decision-making.

The theory behind the latter set of issues is perhaps easier to analyse than the former in that there is a significant body of work from, amongst others, Daniels and Sabin, (2002) about the proceduralist approach to handling ethical issues of healthcare decision-making. They argue that *'the general principles of distributive justice that could give us some guidance about the fair allocation of healthcare services are too indeterminate to tell us how to establish priorities among claimants'.* They go on to set out four conditions that they believe capture the essential elements in achieving legitimate and fair coverage decisions for new treatments, which, in essence, rely upon such decisions being publicly accessible, construed as reasonable, having a mechanism for challenge and dispute resolution, and voluntary or public oversight of the process to ensure that the conditions are met. Similarly, in the UK, McLean (2001) recommended a process for the Highland Health Board to follow as a framework for open and accountable decision-making on priorities for funding. This was based on the identification of a core set of values following a series of interviews with the staff involved and representatives of the public.

These guidelines provide useful frameworks for health service managers and their organisations in setting up clear procedures for arriving at difficult and potentially controversial decisions. However, it might be argued that as such guidance already existed prior to 2002, and because, particularly since the Jaymee Bowen case in 1995, many managers had already adopted clearer and more open procedures, the need for the Code to achieve this aim was superfluous. However, it is striking that the wording of the Chief Executive's introduction to the Code, as quoted above, uses the term '*reassure the public...*' as opposed to, '*assure the public'.* This perhaps indicates an acceptance of the Kennedy Report findings that decision-making was still unacceptably variable and inconsistent and, as a result, reassurance was required.

However, there is also a strongly held view that codification of decision-making in difficult areas such as entitlement to treatment is either inadvisable

or inappropriate, or both. Hunter (2001), in a paper on healthcare rationing, argued that what people want is neither strict explicit or implicit approaches to rationing healthcare, but '*a middle way that encourages defensible and transparent decision-making processes while also allowing individual clinicians the discretion to exercise their judgement and experience'*. Hunter defined this as 'the appeal of '*muddling through elegantly.'* Similarly as part of this research, as will be described in more detail later, a senior figure in the medical profession stated that he did not believe that codes should set out to enshrine processes for decision-making about individual cases because circumstances would always be different and individual judgements would have to be exercised. Again this analysis is not intended to signify that the whole purpose of the Code is negated but to establish in the mind of the reader that even seemingly clear statements of intent in relation to improving public confidence in healthcare decision-making are not without their complications when it comes to trying to reflect these aspirations in any effective way in a Code of Conduct.

The theoretical framework for clarifying and codifying what should be the motivations and priorities of managers in carrying out their responsibilities is more complicated to analyse and depends to some extent on trying to assess what might reasonably be expected from managers in any given situation. It could, for example, be argued that managers should be disposed to act in ways that benefit both the individual and society and that in doing so their actions should be virtue-based. Virtues such as integrity, honesty and justice featuring in a code of conduct or ethics might point to this more substantive approach. Sommers and Sommers (1992) have suggested that a virtue-based approach to ethics has the advantage of providing the moral motivation to act beyond personal or social group interests, but they recognise that this should be set within a wider approach to ethics not based purely on virtues. A virtue-based approach can be seen in the NHS Code of Conduct in the principle '*be honest and act with integrity'*. However, it is by no means clear that incorporation of such virtues in a code can require practitioners, in this case managers, to be virtuous. Some authors, such as Pattison (2001), have argued that:

'The point about moral virtues is that virtuous people will decide for themselves what to do in specific situations, allowing their sense of honesty, or integrity, or justice to direct their actions. No set of rules or clauses in a code can tell us how to act with compassion or courage, still less what amounts to the best interests of any given patient.' Pattison, 2004,P5

It might also be argued that managers should act more from a motivation to perform a duty for others and to show respect for others in what they do. This deontological, or duty-based approach, owes much to the work of Kant (1997) who defined the duty to others as a categorical imperative which the rational human being has no moral choice but to obey. Elements of duty are often explicit or implicit in codes of ethics or conduct. In the case of the NHS Code, '*make the care and safety of patients my first concern and act to protect them from risk'* might be an example of a Kantian ethic. However, such exhortations are often difficult to maintain in everyday life particularly, for example, when decisions have to be made about competing priorities for scarce resources where, arguably, at least some patients' needs may not be met. Also, in the case of the Code of Conduct, there may be tensions between this provision in the Code and the responsibility, which is said to override anything in the Code, to answer to the employers for the delivery of national policies and targets.

Utilitarianism is not explicitly advocated in the NHS Code, although, given the decisions that are most likely to tax managers and the choices that they may have to make, it might be expected to be influential in their thinking. The theory developed by Mill (1998) and Bentham (1970) among others propounded that people should act in ways that give the greatest happiness to the greatest number of people and, as such, in terms of a theory with relevance to the work of healthcare managers it could have a direct bearing on issues relating to entitlement to treatment and the use of resources. The moral dilemma is how to act when trying to do what is right for an individual and, simultaneously, what is right for a community of interests are in conflict. It is possibly on this very issue that decisions faced by managers are at their

starkest and where utilitarianism, or any other theory that relies on a single principle, may not provide much solace. Many would believe that in such circumstances the Code of Conduct should provide protection for the manager as well as giving him or her some clear guidelines. However, none of the principles in the Code make any specific reference to this, possibly in tacit recognition that no code could cover the complicated circumstances of individual cases.

A further potential motivation for managers could be to respect and fulfil what they believe to be people's rights to treatment and service. Indeed this would seem to be advocated in the principle *'respect the public, patients, relatives, carers, NHS staff and partners in other agencies.*' A rights-based approach to healthcare has been promoted by Ian Kennedy in his role as Chair of the Healthcare Commission in stressing the rights of children as a specific area in which the NHS may not be fulfilling its responsibilities and one were the rights are almost inalienable and absolute. O'Neill (2002), however, entered a note of caution about a rights-based approach when she said:

'We fantasise, in my view irresponsibly, that we can promulgate rights without thinking about the counterpart obligations, and without checking whether the rights are consistent with one another, let alone set feasible demands on those who have to secure them for others.' O'Neill, 2002, P

So perhaps in relation to the Code of Conduct, even on the issue of rights that should be respected by managers, whilst it may be argued that some of these are easy to state, it is more difficult to be clear about how such rights should be interpreted and what are the attendant obligations of those exercising those rights. For example, might the respect that managers afford to others be affected by the way in which those others show respect for the role of managers as a reciprocal obligation?

In theory, therefore, in terms of moral motivation, managers may be motivated by a sense of duty, out of strongly held personal beliefs or values, by trying to balance the needs of individuals with those of the wider community, by

respect for the rights of the people they serve, or by a combination of these and other factors that are local to their situation. At this stage, it is possibly fair to say from the theoretical analysis that some or all of these motivations could have an influence on the way that managers act and how they might be expected to act. It is less clear, however, that the existence of the Code could in theory have a determining influence because most of these motivations would seem to be particular to the individual and, therefore, better defined as personal morals. By this assessment a code could be said to be a way of enshrining norms held in common within a particular social group.

Therefore, in terms of the justification for the Code of Conduct, whilst the stated purpose may have been clearly articulated, this analysis suggests that, from a theoretical perspective, there are some outstanding questions about whether the Code can fulfil the stated aims. For example, the aim for the Code to provide a set of professional standards seems to rely to some extent on whether NHS management can be regarded as a profession, and, has been seen, there are problems with this, whichever definition or theory of professions and professionalism is used.

Similarly, in relation to the aim for the Code to provide guidance to NHS managers on the decisions they have to make, there is a view that most of the dilemmas that managers face about decisions relating to entitlement to treatment and use of resources are situational and cannot be prescribed by a generic code, nor would it be desirable for this to be so in the views of Loughlin, Hunter and others.

Even in terms of the aim for the Code to provide reassurance to the public about the decisions that NHS managers make, it could be argued that this relies heavily on the clarity and openness of the decision-making processes and there is already sufficient research and knowledge available to guide managers on this without the need for the Code of Conduct. Furthermore there are doubts about the use of a code to enshrine moral values because these essentially are a matter for the individual based on their own circumstances and beliefs.

My own research will attempt to test how the Code of Conduct has addressed these theoretical issues in practice and, crucially, whether the stated purpose is shared by managers in the field.

Types of codes

Assuming for the moment that the purpose for the Code for NHS managers has been established, the next question might be what sort of code might be needed? The research referred to in Chapter 2 differentiated value-based codes that state principles from compliance-based codes that govern employee conduct.

This seems to be a useful way of looking at what sort of code may be needed for NHS managers; should it be value-based or compliance-based.? The title itself would indicate that the Code is aimed at specifying conduct and, as such, might be seen as compliance-based. Further examination of the supporting information in the Code as to what each of the principles means in practice would seem to point in this direction also, in that it stipulates more closely the behaviours expected from managers in relation to each of the principles. It has been noted that the requirement for managers to observe the Code has now been enshrined into their contracts of employment so this demonstrates further that the authors and commissioners of the Code saw it as being a compliance code. The Code also includes a statement that nothing in the Code requires or authorises a manager to act in conflict with their duties and obligations to their employers and that if such a conflict arises the Code should be set aside. In some quarters this has been seen as a dilution of the main principles of the Code. Andrew Wall (2004) has commented:

'Managers are expected to 'be honest and act with integrity', but they 'must not permit, or knowingly allow to be made, any disclosure in breach of his or her duties and obligations to his or her employer save as permitted by law'. In other words, an individual manager's reservations about, say, PFI [the Public

Finance Initiative], or indeed any other government policy could be suppressed'. Wall, 2004, P73

One way of construing this situation is that the intention was to create a code that managers were required to comply with almost as a supplementary part of their contract of employment, although clearly it was not intended to clash with, or in any way override, contractual obligations. The Code may also have been intended to protect the organisation from litigation or loss of public confidence, and, in the way that the preamble and stated purpose for the Code was written, it could also be concluded that the intention was to 'give the Code teeth' thereby providing the reassurance to the public that managers will be held accountable for their decisions.

However, the Code also demonstrates what at first reading might be termed as elements of a value-based approach. The principle to '*respect and treat with fairness the public, patients, relatives, carers, NHS staff and partners in other agencies'* might be an example of this. However, closer reading of the supporting statement seems to revert to compliance terminology, in that it talks about meeting legal and procedural requirements such as showing respect by ensuring that *' no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin'*. Similarly the principle to be honest and act with integrity is defined in terms of not accepting gifts or inducements and protecting NHS resources from fraud and corruption.

A stronger value-based approach could have been taken in determining what sort of code was needed to fulfil the stated purpose and this might have involved greater emphasis on the establishment of shared values among the community of managers and a more in-depth understanding and articulation of what these values meant in practice. Pattison and Pill (2004) argued that:

'Unless individual professionals have a realistic and articulated understanding of the values that they work by, they are not in a strong position to criticise,

defend or modify them, nor to discuss those values with interested others such as members of the public who use their professional services.' Pattison and Pill, 2004, P203

They went on to suggest that developing this more critical understanding of values might help professionals to comprehend and value their own roles and to engage in more open relationships with their clients. To some extent the Institute of Healthcare Management in producing their Code, which may be regarded as a forerunner to the Code of Conduct, tended more towards this approach identifying key values and exploring through a lengthy consultation process with their members how these might impact on good and bad management practice. Essentially this approach was also taken by McLean in her report for the Highland Health Board (referred to earlier in this chapter) on Making Ethical Decisions in Healthcare. She identified seven key values as being critical to ethical decision-making in the light of discussions and interviews with all stakeholders and explored what each of these values meant in relation to the decisions about healthcare that the stakeholders, or others on their behalf, would need to make.

Another way of looking at what type of code might be needed would be to consider what sort of code would meet the desire to reassure the public about the decisions that NHS managers make. Whilst it is probably true that patients will judge the NHS by their own personal experience of it, there may also be a case for recognising in the Code of Conduct those rights of patients and others that managers should respect and uphold in their decision-making, and to do that in greater depth than would be required by a more compliance-based approach. This might amount, for example, to recognising what has been termed as procedural rights in the sense of the rights to fair treatment (in the non-clinical sense) of individuals as they come into contact, or try to come into contact, with service providers. This definition was provided by Coote and Hunter (1996) and they went on to offer a framework of such rights that included the right to be heard or consulted by a person or body making decisions that affect their circumstances, and a right to consistency in decision-making. Such a framework could have been used to clarify and

amplify the responsibilities of managers under the Code, both in relation to their decision-making processes and the need to reassure the public about these processes. The fact that no such initiative has yet been taken with the Code of Conduct seems to indicate that this approach was not thought to be appropriate, or that it has not been considered.

In terms of this analysis of types of codes, therefore, it seems that it is clear that the Code of Conduct for NHS managers manifests strong elements of a compliance code. However, like many of its counterparts in corporate and professional life, it also seeks to articulate some preferred values, though in a somewhat less convincing way than the compliance requirements.

The formulation of codes

The analysis so far in this chapter has explored the theory behind the stated purpose for a code and the types of codes that might be needed. The question now to be addressed is how should a code be formulated?

Here it might be appropriate to remind ourselves that a code of conduct cannot solve all ethical problems. Aristotle (1962) stated:

"But we must remember that good laws, if they are not obeyed, do not constitute good government. Hence there are two parts of good government; one is the actual obedience of the citizens to the laws, the other part is the goodness of the laws which they obey." Aristotle, 1962, P103

The significance of this statement to the NHS Code of Conduct is that, were we to accept that the purpose for the Code was good, it would still be necessary to ensure that it would be likely to be accepted and adopted by the community of NHS managers for it to meet Aristotle's test of good governance. How might this be achieved? A first principle in relation to most of the research on codes of conduct and/or ethics for organisations seems to be that the group of people whom the code is aimed at must be significantly involved in its formulation. The Organisation for Economic Cooperation and

Development (2000), in a report which reviewed ethics measures for public services in 29 countries, found that:

'The involvement of the staff concerned was a crucial factor for establishing mutual understanding among public servants and lead to a smoother implementation later.' OECD, 2000, P12

Evidence from the development of parallel guidance for the recognised NHS professions would seem to bear this out. For example, the specific guidance for doctors involved in healthcare management, such as the General Medical Council's document "Management in Healthcare: The Role of Doctors", referred to earlier, was developed by the profession itself and involved detailed consultation through the various representative committees and branches. Significantly, perhaps, the Code of Conduct for managers was commissioned by the employer, that is the NHS Chief Executive, and developed by a small working group in a short timescale, with what some would argue to be inadequate time for meaningful consultation. Furthermore, as referred to earlier, the resultant Code has been enshrined within the manager's contracts of employment so in no sense can it be regarded as voluntary.

Wainwright and Pattison (2004) counselled caution when considering how codes were formulated. They found that, whilst most codes were presented as consensual documents without sectional interest or prejudice, in reality they were often drawn up by a small group of enthusiasts and ended up being *'rather partial documents'.* They were of the view that:

'Generally more people need to take more active responsibility for the writing, implementation and interpretation of the values implicit in codes as part of being active professionals. Professional values as expressed in codes should be real, espoused and enacted values of many, not just the aspirations of an elite few.' Wainwright and Pattison, 2004, P121

Experience with the medical profession has also shown that attention needs to be paid to how training and education about the requirements of new guidance will be provided. In the case of the Guide to Good Medical Practice, for example, the need to build appropriate training into the syllabi for post graduate courses has now been established and this ensures that all doctors in training receive tuition and familiarisation with the requirements. Even this is not thought to be enough in some quarters. Dame Janet Smith, the author of the Report of the Shipman Inquiry, was recently reported (Guardian, May 10 2005, P.9) as suggesting that there should be tests to ensure that medical students had absorbed the ethical principles that should govern their careers as doctors, and she was reported as going on to assert that:

'Knowledge and skills can be enlarged and enhanced as you progress through your professional life but ethics and attitudes are fundamental and have to be planted right at the beginning.'

At the very least, therefore, it might be argued that the right time to specify the tuition and training in ethics or values promulgated in a code would usually be at the time that the code or guidance was being formulated because this would help to provide a discipline around how the values could be interpreted and applied in practice. The process for the Code for NHS managers does not appear to have taken this point into account; possibly because this was not seen as a priority or it was felt that it would follow at a later stage.

Similarly, attention needs to be paid to the way that the code is to be publicised. Firstly, in so far as the community of NHS managers is concerned, it is clearly important that they have an awareness of the Code of Conduct and an opportunity for dialogue with those involved in its formulation. As indicated by the earlier example quoted in Chapter 2 relating to the publication of the Code of Professional Practice for the Nursing and Midwifery profession where many nurses said that they were unaware of the Code despite the fact that it had been mailed to all registered practitioners, it cannot be assumed that simple publication in written form will secure awareness. Further still, if it is intended that managers should have an understanding of what is in the

Code of Conduct, not simply an awareness of its existence, this might involve initiatives such as workshop sessions or meetings of managers to clarify and raise questions about the Code and the practical implications. It is also likely that such discussions will not be one-off meetings as the experience of the Code in action will need to be shared and distilled if it is to be kept up to date and relevant in changing circumstances. This may be important in terms of reinforcing commitment from managers to the Code and the specific principles.

Perhaps of equal importance in terms of publicity for the Code is how it will be made known to and understood by others to whom it relates. The Code for managers incorporates clear statements about their responsibilities to a wide range of other parties including the public and other NHS staff. It would therefore be appropriate to be clear about how the Code will be made known to them beyond simple publication, and what they might reasonably expect from managers as a result. In so far as the public is concerned, for example, Pattison (2001) has found that, although professions like to present codes as being for the benefit of the public, members of the public generally have little say in the contents or administration of the codes. Often they do not know that the codes exist, or what rights they have in relation to them. So publication in any meaningful way needs to be carefully thought out and implemented.

Finally, in relation to how the code should be formulated, one organisation in the United States (the Ethics Resource Center at www.ethics.org) summarized the key stages in code development as:

- Planning the work
- Collecting data – including researching relevant other codes
- Writing the draft code
- Specifying the reporting and enforcement mechanisms
- Having the code reviewed in draft form by an informed body/individual other than the authors
- Obtaining board and membership approval

- Choosing communication and education strategies
- Scheduling code updates and revisions

It seems likely that the process for the development of the Code of Conduct for NHS managers may have included at least some of these stages in its formulation, but it remains to be seen whether, in practice, the process adopted could be viewed as comprehensive or appropriate for the purpose.

The use and application of codes

Again, in assessing how a code should be used, it is important to return to the stated purpose for the code. For example, is it intended to guide the individuals concerned by, say, defining acceptable behaviours and providing a benchmark for self-evaluation, or is it to set out a list of requirements that those individuals will be expected to meet and which will be externally monitored and enforced? In reality many codes, including the Code of Conduct, seem to incorporate both of these aims. Certainly the preamble and the first principle of the Code stating that it is intended to guide managers in the work they do and the decisions they make would indicate that it is primarily intended to guide by setting out appropriate behaviours. But, as discussed earlier in this chapter, much of the rest of the Code and the supporting detail seeks to set out a list of requirements backed up by enforcement through employment contracts.

Furthermore a process has now been set up to monitor and enforce the Code in practice. Following a statement at the time of publication that arrangements would be put in place to investigate any reported breaches of the Code by persons trained to carry out independent reviews; action has been taken through the NHS Confederation (the employing authorities association) and the Institute of Healthcare Management to start this process. However, is not clear at the time of writing how this will work in practice as there is little, if any, experience of the process in action. It is clear, though, that the process is retrospective and will be triggered by concerns expressed about the conduct

of individual managers by others. A more supportive approach was originally envisaged by the Institute of Healthcare Management by incorporating compliance with their Code within a continuing professional development initiative The IHM Code went on to state:

'Having procedures to censure members and change their membership grade from full to associate if future individual CPD requirements were not complied with was considered necessary but to be used only as a last resort. CPD and Code are about development not punishment. The Institute has a leading role to play in promoting the positive aspects of providing members with a set of standards and a framework for their working careers.'

It is not clear whether the Institute is still pursuing this initiative, but it would seem that, to all intents and purposes, the Code of Conduct has now superseded the Institute's Code in that it applies to all managers irrespective of whether they are members of the Institute. What is clear from the published material at this time is that no central initiative on the part of the authors of the Code of Conduct, or the employers, has been taken to support managers in its use and application.

Summary

This chapter began by exploring the question to why a code of any kind might be needed. The foregoing analysis of the theoretical basis for codes shows that there may be several reasons why codes may be thought to be required and that clarity about the purpose is an important starting point. The Code of Conduct for NHS managers certainly had a clearly stated purpose in the form of the preamble by the NHS Chief Executive, but, in the light of the theoretical evidence presented here, this could also be said to be ambiguous and ambitious in its scope, including aims to provide guidance to managers on the decisions they have to make, set professional standards for managers, and provide reassurance to the public.

Also considered in this chapter is the question as to what type of code may be needed to meet a stated purpose, and some evidence exists to suggest that the Code for NHS managers might primarily be termed a compliance-based code. However, there is also an expressed intention from the NHS Chief Executive that the Code be seen as a set of underpinning values. Here, again, there are reasons to be cautious about the extent to which a code can tell managers how to act in relation to moral virtues such as honesty or integrity because these are personal to the individual and the situation and may only be influenced in a limited way by a set of rules that are externally imposed.

In so far as how a code might be formulated, possibly the most striking point from the theoretical analysis is the importance that is usually ascribed to the direct involvement in the process of the members of the group whom the code is aimed at. It remains to be seen as to whether the process adopted for the Code for NHS managers will be owned in practice by the management community.

Finally, in this chapter, the issue of how a code might be used and applied and the evidence relating to how the Code of Conduct will be enforced is considered. This seemed to be in line with the earlier analysis suggesting that the Code could be viewed primarily as a compliance-based code.

On most if not all of these issues there is more that could be said in relation to the theoretical basis for codes in general. The intention in this chapter was to explore those that seemed to be most relevant to the process adopted for the Code of Conduct for NHS managers to provide a framework for the research into the practical value of the Code as experienced by the management community that it is aimed at. With that in mind, this chapter has served to demonstrate that, whilst it is possible to form some understanding about the theoretical framework for the Code of Conduct for NHS managers, and, as a result, to raise certain questions about codes in general and this one specifically, there are significant outstanding issues relating to its fitness for purpose that can only be resolved by an assessment of its application in practice.

CHAPTER FOUR

STUDY DESIGN AND METHODS

This chapter sets out the rationale for the approach that I adopted for my research and my method of gathering material. It is intended to orientate the reader for the presentation of the findings in Chapters 5 and 6 by describing and justifying the framework that I adopted, and providing the necessary link between the earlier chapters on the development and theoretical framework for the Code and the research into its use and application in practice.

My aim

Having provided some analysis of the stated purpose of the Code of Conduct for NHS managers as set out in the published documents and the supporting information, it is important to restate my aim in carrying out research into the practical use of the Code by NHS managers. My interests were in exploring the extent to which the Code is seen to have practical value for managers in their day-to-day work and decision-making and whether the aims and aspirations of its authors are shared by managers.

For these reasons the research for this part of the study involved, firstly, obtaining the views of the members of the group responsible for formulating the Code, and secondly, those of a cross-section of managers 'in the field'. The intention was that this research would provide the evidence of how the Code has been received and applied in practice and, maybe also, contribute to the wider debate as to whether codification of desired or required forms of conduct can help managers and raise ethical standards of management and management decision-making.

My methodology

My chosen methodology was informed by Judith Bell's work on Doing Your Research Project (1999). She suggested addressing three key questions to determine a research methodology:

- What do I need to know and why?
- What is the best way to collect the information?
- What shall I do with it?

What do I need to know and why?

The most important part of this aspect of the research was to obtain the personal views of managers and the authors of the code itself. This was essential to compare these views with the published documentary information in the form of the Code itself and the related Managing for Excellence initiative. In particular I needed to know what the aims and aspirations of the authors were, how they felt the Code should be used and applied and why they believed that it made a worthwhile contribution to NHS management. I wanted to pursue with them their own thoughts about the purpose of the Code and how they personally might use it in their own professional life. In the light of the earlier analysis of the theoretical framework I was also interested to pursue with them whether they saw the Code as largely a value-based code providing guidance to managers or a compliance-based code setting out requirements for managers to follow. There could also be relevance in seeking their opinions about the way that the Code was to be enforced by incorporation into manager's contracts of employment. This information would deepen my understanding of what the authors were hoping that the Code would achieve and serve to clarify the congruence between the views of the individual members.

In so far as managers 'in the field' were concerned, I considered that the same areas of investigation could be pursued with them to provide the comparison with the aims and aspirations of the authors, but this could be supplemented by ascertaining their opinions about the Code itself and how

valuable they thought it to be in any or all of the areas that it was intended to cover. This, I considered, would need an approach that gave me the opportunity to explore directly and in some depth how they viewed the Code within the reality of their day-to-day activities. Importantly I also needed to know their 'take' on the way that the Code was to be enforced.

I also felt that it would be useful to look at a case study of a real-life management issue where the Code had, or might have been expected to have had, relevance and application. The sort of issue I had in mind was a decision that a manager or board had had to make and where the choices were not straightforward and/or were potentially controversial. This would be just the situation that, according to the published information, the Code was designed to help with, such as the sort of cases discussed in my earlier chapters. Reflections from a manager who had been involved in such an episode could provide direct feedback on the value of the Code to complement the more detached, objective views of other managers.

What is the best way to collect this information?

Using Bell's framework I arrived at the view that the information I needed was largely qualitative in nature and could best be collected by means of a questionnaire-based semi-structured interview approach. The questionnaire incorporated standard questions designed to elicit responses from all participants so that the answers could be quantified in a reliable way. However, in addition, the semi-structured questions gave me the opportunity to pursue more detailed personal responses that gave the necessary depth to the material for analysis. Because I was adopting an approach that relied on being able to develop a dialogue with respondents on some questions, it seemed logical that I should use personal interviews as my main method of gathering the information.

In terms of the range of participants, I felt it important to interview as many of the individual members of the Code group as possible. This ensured that the spread of views from that group was wholly representative of the different

constituencies from which the group had been drawn. I was also able to draw on my own experience and network of contacts at senior management level in the NHS to identify and secure cooperation from a range of managers in the NHS who were willing to participate in the study.

My preference in relation to the case study was to find an example where an NHS organisation was undertaking a public consultation exercise to consider significant changes in service provision which would affect access to certain services for the public. My own experience suggested that this was exactly the sort of issue where ethical and procedural issues came to the fore and such situations also involved the NHS body concerned relating directly to the public. This therefore contained a number of the elements that the Code was meant to cover; guidance to managers on decision-making, respect for the public and other partners, reassurance to the public about NHS decision-making and the application of stated values such as honesty and integrity. If the Code was seen to have value in such a real-life situation it might go a long way towards providing some positive answers to my questions relating to the use of the Code in practice. To do this, however, I needed to identify an NHS body currently dealing with such an issue, obtain their agreement to be part of this study, and design a questionnaire to elicit their views in such a way as to be reliable and valid for my study.

What shall I do with it?

Addressing this question in advance of commencing the research was a useful discipline in that it meant that I had to think through how I would collate and analyse the material that I wanted to collect, and this, in turn had an impact on both content of the questionnaires themselves and the number and choice of organisations/individuals that I invited to participate. I decided that the questionnaires should include no more than twenty questions and that each question should be self-contained, seeking, wherever possible, a short answer which would help in arriving at valid and quantifiable results. This would make the analysis of responses to those questions easier and more reliable. Where I anticipated using questions that sought more detailed

qualitative results, I decided that it would be necessary to transcribe the responses directly and to check my understanding with the respondents at the time to try to ensure that these responses, also, were accurate and reliable.

In so far as the number and choice of individuals themselves were concerned, I needed to balance the requirement to obtain a sufficiently representative set of views with the practicality of travelling and conducting interviews and analysing the results. I therefore chose to limit the geographical spread of managers that I approached to give the 'field' perspective to the north of England. As well as being manageable for me in terms of travel, this also had the effect of drawing a boundary within which I already had an extensive network of contacts that made it easier for me to approach and get cooperation from possible participants. I did not consider that the geographical boundary would invalidate the results because I was still able to ensure that all levels of the current NHS organisational structure were included in the exercise. This geographical constraint in relation to the managers I approached did not apply to the members of the Code group where I travelled to the locations of the members to carry out the interviews.

Ethical aspects

Whilst the fact that I had extensive experience in NHS management meant that negotiating access to those I wished to interview was easier, it also highlighted the need for me to exercise care in misusing my contacts and in avoiding bias in my approach. I was greatly assisted in this by my supervisors who vetted my proposed interview questionnaires and offered guidance on the conduct of the interviews. As a result I devised a protocol (Appendix 2) for the interview process that included:

- A brief outline of my research topic and my area of interest
- A copy of the questionnaire
- A statement that I used at the start of each interview giving an undertaking that I would use information given in the interviews with

discretion and that, in cases where I wished to use direct quotes from named individuals, I would check with the person concerned before including this in my final thesis

- An assurance to participants that I would do my best to respect any wishes to remain anonymous
- An assurance that, if at any time during or at the end of the interview, a respondent felt that their interests would be prejudiced by continuing to participate, they had the right to withdraw

These measures were intended to safeguard the ethical aspects of the conduct of the research and throughout the process I was able to call on my supervisors to advise on any matters of concern.

The principles in practice

Having prepared the questionnaire and settled on a process for the interviews, I carried out a trial with a colleague to test the clarity of the questions and the likely amount of time that I would need to devote to each one. This indicated that around forty five minutes would be a reasonable estimate and I duly informed each participant in advance that the interview would take approximately that amount of time. In practice, probably because some of the questions sought a more detailed qualitative response, some of the interviews tended to extend to around one hour. Where the participants asked that we keep to the suggested time I was able to achieve that and still cover all the questions, albeit not always in the same amount of detail.

The list of participants that I chose to approach included all but one of the members of the group set up to formulate the code, a list of whom is included at Appendix 3, (having already been made public in the publication of the Code and the supporting information). In so far as the managers 'in the field' were concerned, these included Chief Executives in a Strategic Health Authority, Hospital Trusts, a Mental Health and Community Services Trust and a Primary Care Trust. All interviews were carried out over a six month

period in late 2003 and early 2004. The results were transcribed by me at the time but analysed at a later stage together with the outcome of the literature search and the documentary evidence in the form of the Code itself and related information.

I was also able to secure the cooperation of a Primary Care Trust to carry out a case study into a consultation exercise the trust had completed on a service reorganisation project. This had involved a sensitive and potentially controversial set of proposals to change the role of a small community hospital in a market town which would result in some services being moved to the nearest district hospital. My primary interest here was to interview the chief executive to find out to what extent the Code of Conduct was helpful to her in this exercise, whether she felt that it offered her protection or made her more accountable for her conduct in guiding and advising her board and in her relationships with the public and other interested NHS organisations and partner organisations.

A secondary interest that I believed was germane to my study was to find out what the chair and other non-executive directors felt about the importance of the Code of Conduct for the chief executive and whether they saw it as part of their role to monitor how she conducted herself throughout the process, and, if so, how they went about this. This was what was envisaged in the measure to include adherence to the Code in manager's contracts of employment, in that chairs and non-executive directors were expected to take action where they suspected that any breaches of the Code had taken place. This seemed to indicate knowledge and understanding of the Code on the part of those individuals and active monitoring in cases where the Code might have been expected to have an important influence. Whilst recognising that it would not be possible to generalise the results from this case study, it would also provide some degree of triangulation with the results from the individual interviews and the review of the documentary evidence.

Summary

My methodology for this part of the study, therefore, comprised the following elements:

- The use of a standard questionnaire incorporating some questions designed to produce quantifiable responses coupled with some questions that encouraged more subjective descriptive responses to provide greater depth to the research
- A series of semi-structured interviews each lasting approximately forty five minutes and intended to provide a comparison between the aims and aspirations of the authors of the Code and the experience of practicing managers
- A case study to assess the value and application of the Code of Conduct to a chief executive and board members in a public consultation exercise to obtain the views of the public on a set of proposals to change the range of services in a community hospital

Chapter 5: The findings

This chapter presents the findings from the interviews with the members of the group set up to produce the Code, and from the interviews with managers 'in the field'.

These interviews were centred on a standard questionnaire, (a copy of which is attached at Appendix 2). This questionnaire consisted of 18 questions designed to elicit information on how participants viewed the purpose of the Code, their own aims and aspirations for it, and how they might use it in their own practice. What follows here is a presentation of the findings under the following headings:

- What led to the Code? The background to the Code and how it evolved
- The purpose of the Code. What were the hopes and aspirations for it and what did people believe that it could realistically achieve?
- How should it be used? By the various bodies and individuals that it was produced for, including managers, employers, patients and public, other NHS staff, and partner organisations
- What are its limitations? Both inherent and in practice
- How should it be developed? Will it be reviewed and revised in the light of practical experience?

The background to the Code and how it evolved

The views of Code group members

There were some differences of view about what led to the Code, although all participants recognised that the Kennedy Report had been instrumental in bringing the need for a code to a head .However, whilst one member stated that the commissioning of the Code by the NHS Chief Executive was a pragmatic response to the criticism in the Kennedy Report and, as such, provided the sole impetus for the Code, others felt that the pressure for a

code for managers also owed something to the increased interest in codes in other walks of life, one participant remarking that "everybody has one".

There was also a view that the Code reflected wider concerns within the NHS, and some of the representative bodies from whom the members of the group had been drawn, that managers either lacked the framework of ethics and values that other NHS professions had or were being disadvantaged by not having the protection that a Code of Conduct might be seen to provide in cases where they believed that they were being subjected to excessive political pressures. One participant stated that the motivating force for the Code of Conduct was the way that the role of managers had changed over the years. This meant that they were now responsible for managing groups of staff with clear codes of professional practice and it was therefore no longer tenable for them to have no clear Code of Conduct governing their own actions. In his view the Kennedy Report was a reflection of what many people inside the NHS were thinking on this issue and provided the political incentive to make the production of the Code a necessity.

One participant felt that an important part of the background to the Code was the way in which managers had increasingly been faced with meeting sets of absolute targets when "management and life are not absolute". As a result managers were often faced with difficult ethical choices between doing what they believed was right or simply focussing on delivering the targets. For the member of the group who expressed this view, it was therefore important that the Code enshrined some rights for managers as well as a set of obligations. Without this it was feared that managers would continue to feel pressured into "gaming the system" by trying to meet the local demands whilst also "keeping the people above them happy".

Most members also felt that the status of managers formed an important part of the background to the Code, particularly in relation to debates that had taken place in recent times about the extent to which management in the NHS could be said to be a profession. Perhaps not unreasonably considering that most of the members were from representative bodies; this was a 'live' issue

that had to be taken into account in the formulation of the Code, although there were differing views on the issue. Some believed that the "jury was still out" as to whether NHS management was a profession whereas others believed that there was now a strong groundswell of opinion that professional status would be both opportune and necessary to place managers on an equal footing with their clinical colleagues.

In so far as the evolution of the Code was concerned, all members acknowledged that, whilst the Code had not been specifically modelled on any existing code, it had been important to create commonality with other codes and guidance, particularly the Guide to Good medical practice (GMP) for doctors . Most participants also mentioned publications such as the Nolan Principles and the Institute of Healthcare Management code as having been influential in the approach taken to formulating the Code. All members stated that there had not been any need for the group to seek any external guidance from experts in the field of ethics because they felt that there was sufficient knowledge and experience within the group to fulfil the brief that they had been given and to produce a code that met the requirement as they saw it. Similarly all the participants were happy with the process adopted for the consultation that they as a group undertook on the Code although most pointed out that they had been given a short timescale to produce the Code and this inevitably limited the consultation period.

The views of managers and other participants

Managers who participated were unanimous in their observations that the main motivating factor behind the Code was the Kennedy Report and that, as such, some sort of response of this kind was necessary. Beyond this, however, views about what led to the Code ranged from a pragmatic acceptance that" managers needed something as a reminder of the values that NHS managers should espouse", to a perhaps more cynical view that it reflected the continuing trend towards top-down management, with a belief that it had been commissioned by the NHS Chief Executive to give him more control over how managers should behave.

There was some recognition that managers needed some protection from what were seen as "capricious, politically motivated policies which placed them in perilous situations", but little sense of the Code providing this protection. Indeed the responses indicated that the belief was that the Code had come about purely as another means of holding them to account rather than providing them with protection or rights. All respondents made reference to the background to the Code having been influenced by the debate about whether NHS management is a profession or not. Most felt that in comparison with the accepted NHS professions such as medicine and nursing, management could not be seen as a profession. Interestingly, there seemed to be little enthusiasm expressed for pursuing such a goal, with much more emphasis placed on the need for managers to stay true to their own personal code of morality and act in an "authentic way as a leader". There was, however, some recognition that the events of recent years may have shaken the public trust in managers, but little acceptance that the Code of Conduct could do anything significant to address this shortfall. Rather participants felt that the image of managers was reflected in the public view of the organisations that they were responsible for managing and that many of the issues that they faced were situational and local and required judgement and local knowledge not a written code.

Interestingly none of the participants felt themselves to be at a disadvantage in their relationships with clinicians in the past through not having had a code of conduct, but there was a feeling expressed that increased emphasis on achieving political targets had contributed to a climate of suspicion and, in some cases, this had engendered a lack of trust between managers and clinicians at local level. One participant commented that he had been involved in discussions with clinicians to consider how this could be repaired and he had noted that there was a feeling amongst doctors that a code of ethics or conduct setting out clearly what was expected of managers would help them to understand "what was appropriate behaviour and what wasn't and to challenge or support managers accordingly". In the view of this participant, this would constitute a good reason for having the Code – in his mind meeting

the needs of other people in their relationships with managers and giving them an understanding of the legitimate and appropriate ways that managers should behave.

Most participants felt that the way the Code had evolved had left little room for consultation and influence from managers in the field. Some seemed unaware of how the consultation had been carried out and one commented that this "was consistent with the real aim which was to produce something that met the needs of the centre in a very short timescale". None of the participants felt that the group or the way it was constituted was inappropriate for the task but there was little sense that the resulting document was owned by the management community. Most participants cited this as further evidence for their belief that the Code was purely a response to a political necessity rather than something that they felt that they had influenced and contributed to.

The purpose of the Code

The views of code group members

All participants were clear that the short term purpose for the Code was to meet the criticisms of the Kennedy Report, but, in answering the question as to how they would like the Code to be viewed by managers in 3 years time there were some variations in responses. For example one suggested that he hoped the Code would be seen "as a practical guide to action and to help managers facing ethical dilemmas". Another stated that she hoped the Code would be seen "as a positive contribution to managers being accepted to work on an equal footing with their clinical colleagues so that they can work together more constructively in the future". A third said that "the long term purpose must be to improve patient care and reassure the public" and that she hoped that managers would feel that the Code had helped them to do that

These responses confirm that the authors of the Code, whilst being realistic about the task that faced them, and the need to fulfil the short term requirement, were nonetheless also motivated by longer term hopes and

aspirations. This was perhaps best expressed by one participant who said that his belief was that the Code "was about treating other people as you would want to be treated yourself by showing them common courtesy and respect". As to whether the Code would be likely to achieve these aspirations, most participants were more sanguine in their remarks. One said that the Code had already fulfilled its main purpose, which was to give Ministers and the Chief Executive of the NHS a response to the Kennedy Report, but he was "sceptical about whether it would change management behaviour". Another said that her realistic hope was that the Code would bring about a better understanding by doctors and "the outside world" of what managers stood for. There was also a view that the real importance of the Code was as a symbol that managers would stand up for certain principles, and that, she was "a great believer in the value of symbolism".

There was some difference of view about whether the Code was aimed at guiding the way that managers act or setting out the qualities that are required in managers. Most participants felt that the Code was intended as a guide for how managers should act but there was also a view that it was somewhere between the two, one said that the way she would express it was that the Code had set out the values and expectations that people might reasonably have of managers, both in terms of how they should act and how they should behave.

I also asked the participants whether they felt that management behaviour was currently significantly out of line with the Code and there were different responses here, too. One indicated that she believed that this was not the case generally but that government pressures to achieve targets often "forced managers into potentially unethical territory ". She felt that the Code, whilst not preventing someone acting dishonestly if they were so disposed, might at least be a reference point for people who were unsure what to do in such circumstances. Another, however, was unequivocal that current management behaviour was out of line with the Code saying that managers had been led to believe that their job was to achieve central targets at any cost, and quoted an example of having had a heated exchange of correspondence with an NHS

manager who took exception to the priority set out in the Code to make patient safety the top priority for all managers. The manager in question stated that for him the top priority was to achieve his financial targets. Such beliefs, in the view of the participant, were not uncommon amongst managers and indicated the extent of the rift between the Code and current management values. He hoped that the Code would help to "take managers back to their roots as far as what is really important". A view was also expressed that part of the NHS Chief Executive's motivation in commissioning the Code was to give a signal that, whilst the majority of managers was acting in an ethical way, a minority was not and the Code would demonstrate that such actions would not be tolerated in the future. In this sense, the participant believed that the Code "was setting the bar at a higher level for everybody".

The views of managers and other participants

The manager's responses to the question as to the purpose of the Code and what they thought it might achieve followed similar lines to their responses to the earlier question about why a code was necessary: on the one hand they were pragmatic about the purpose being to assuage the criticism of the Kennedy report, and on the other there was a feeling that the real purpose was" to enable the centre to police managerial activity". There was a view that in the longer term the Code might increase public accountability and that it could increasingly feature in training and personal development activity for managers. It was thought that it may make life more difficult for some managers and make them less willing to take risks.

Echoing the view of one of the Code group members, one manager felt that the real purpose of the Code was as a symbol - almost in the style of the Hippocratic Oath for doctors – it would be a statement of values that managers should espouse but it would not guarantee appropriate behaviour. A point that was raised by more than one manager was the relationship between a code of practice on the one hand, and innovation on the other, with the concern being that managers were constantly exhorted to change practices and cultures but often felt unsupported when things occasionally

and inevitably went wrong. The unanimous view from managers was that the Code would do nothing to help them in such situations and that the reality was that it may even act as a further restraint.

One manager felt that the Code was "laudable but limited" in its purpose in that it tried to lay down a set of ethics and behaviours which only made sense in the context of a profession and, in his view, because NHS management is not a profession, the Code cannot be enforced other than by the employers. Therefore it loses the central importance that a code has for a profession such as medicine and is relegated to being "part of the disciplinary processes". Even this limited role for the Code was questioned by one participant who said that the fact that managers already had clear and unambiguous responsibilities as legally accountable officers for all aspects of the management of their organisations meant that the Code was pretty much redundant other than as a supplementary tool in cases where the manager had demonstrably failed in his/her responsibilities. However, another manager thought that, despite it being clear that the only substantive purpose was to provide an answer to the criticisms in the Kennedy Report, the Code had had a knock-on benefit. Namely that it gave managers "a bit more ground to stand on in their relationships with doctors". Managers generally were ambivalent about what difference the Code would make, believing rather that their own personal ethics would always be what governed their behaviour not a written code and that, for the most part, they felt unengaged with the process of producing the Code and, therefore, didn't really identify with the product. One commented that the Code was not "embedded" either within the management community or the wider NHS and he doubted that it ever would be other than as "a vehicle to be wheeled out when an employer wants to get rid of the manager".

On the issue of how far management behaviour is currently out of line with the Code, most managers, perhaps unsurprisingly, felt that they were acting ethically and appropriately but confirmed that they felt greater pressure on occasions to reconcile the political demands to deliver targets with the need to stay true to their own values. The consensus view was that the Code was

seen as a missed opportunity to have a real debate amongst managers about how such dilemmas could be resolved. Most were disappointed that this chance had not been taken and one remarked that he was angry that the Code had been a "quick fix that didn't solve anything but provided a political comfort blanket for people at the centre". Another manager felt that "it was better to have a code than not to have one at all" but went on to say that it would only have lasting impact and relevance if it is part of a wider understanding of what it means to be an NHS manager. He did not detect any appetite for such a debate amongst his colleagues at the moment. Similarly another manager commented that the Code seemed to fall between two stools, in that, if it were intended primarily as a set of standards that managers were expected to adhere to, it had not been comprehensively introduced and followed up; whereas if it were intended as a guide for managers there had been no real attempt to engage with them to "win hearts and minds".

Most managers felt that the Code had had little impact since its introduction, mainly because this would have had to come from the centre as they were the people who commissioned the Code and, as one manager put it, "there had been no push for it from the managers". One manager when asked what she felt the reaction of managers generally had been to the Code said that she thought that "it had been received with bland indifference". Despite this all managers confirmed that they had now had the Code incorporated into their contracts of employment, as required by the NHS Chief Executive, and one indicated that he was now proceeding to introduce it into the contracts of his managers. Another manager said that "if the centre wanted the Code to be taken seriously they should have performance managed it in the same way as all other high priority central policies". A more favourable response from one manager was that he had found the Code to be a useful reminder of the values that NHS managers should espouse and that he could envisage it being useful to assess the extent of any wrongdoing by a manager. However, he also added, "that said I wouldn't expect it to be regularly referred to".

The use and application of the Code

The views of code group members

All participants believed that the Code should be consulted by managers when they were facing difficult ethical choices and that, in such circumstances, it would provide guidance on the appropriate way for them to act. Having said this, one participant also said that "it is not an earth-shattering document so I don't think that it will be used to inform everyday activities". However, she went on to explain that it should be used in change situations such as when the new NHS Foundation Trusts came into being and the whole issue of private/public sector differences in values has to be addressed. She remained sceptical that this would happen because the political pressure would be to adopt the private sector entrepreneurial values and approach.

Participants were split in their view as to whether the Code was primarily intended to guide the way that managers should act or set out the qualities that managers should possess. One felt that it was clearly the former with the safety of patients being the guiding priority, another felt that it was somewhere between the two, and a third felt that it was both but only as a step along the way to full professional status for managers.

Insofar as how the Code might be used by others, two participants said that the Code had been well received by other NHS professions, notably doctors, and one said that if we were to take the reactions of the media as being in any way representative of the public, it had been interesting that these fell into two camps; "those who see the Code as a further stick to beat us with, and those for whom it provides some evidence that we have a set of principles that are appropriate for what we do and that helps their understanding of the issues". Most felt that it was important that the Code had been given "teeth" in the form of being incorporated into managers' contracts and this would help to give it credibility in the eyes of others.

It was also felt that the development of a list of assessors who could be called in by health bodies or individuals to review decisions by managers where it

was suspected that they had breached the Code would further reinforce in the minds of managers and others what was expected of managers, and that there was a process for people to follow when they were unhappy with the manager's conduct. Indeed one participant suggested that in due course transgressing the Code might be seen as more fundamental than committing a disciplinary offence and that "whilst a disciplinary offence may not mean that the manager is unemployable anywhere else, a breach of the Code will almost certainly mean that their career in the NHS is finished". Although participants acknowledged that the Code as yet was not widely known about beyond the management community, there was a belief that the fact that it had been posted on the NHS website and given prominence there as part of the NHS Chief Executive's commitment, meant that it would rapidly become known about and a case history would be established. One participant stated that he had already been contacted by a patient who had read about the Code on the website and wanted to make a complaint about a local NHS manager.

Almost as a consequence of this belief in the longer term importance and influence of the Code, most participants were disappointed that the Code had not in their view been properly followed up, sharing the views expressed by managers in the field that familiarisation and training should have been provided to ensure that managers understood the Code and recognised how and when they were expected to use it. One participant said that he suspected that "this was not part of the NHS Executive's agenda". Mention was made in this regard of the work that the Institute of Healthcare Management was doing to incorporate their code in a programme for continuing professional development (CPD), and the way they were publicising and debating the Code in their monthly magazine for members. All participants considered that there was no significant conflict between the Code being used by managers to guide their actions and being used by others to hold managers to account.

There was unanimity on the issue of whether it was right to incorporate the Code into the contracts of employment for managers, all participants saying that it meant that managers were now both publicly and contractually bound

by the Code. Without this, participants believed that the Code would have no legitimacy. One participant went further in suggesting that, similar to the mechanisms that existed for doctors, there should be a standards committee or supervisory body to police the Code in action and to sit in jurisdiction on alleged breaches. This, again, was thought to be entirely consistent with a drive for professional status. It was also suggested that the whole issue of training and development of the Code should be the responsibility of a college of NHS management along similar lines to the Royal Colleges of Medicine and that this would resolve all the anomalies of the status of NHS management and its equivalence to the NHS professions.

Although at the time of interviewing the Code group participants, none of them had come across any instances of breaches of the Code, all were of the view that there had been a number of instances in the recent past when, had the Code been in operation, it would have been invoked. Examples included the manipulation of waiting list statistics in Manchester and Bath. Since that time, however, I have been made aware of one instance where a medical consultant in an NHS trust has made a complaint against the Chief Executive of the trust on the grounds that he has breached the Code in relation to his dealings with the consultant and that this is part of a pattern of unfair treatment of that individual. This has triggered the assessment process and the appointment of an investigating officer. I was able to interview this person, not on the facts of the case but on how he viewed his role, the clarity of the Code as he saw it , what impact he anticipated his review might have and what sanctions might result. He informed me that he had received training as an assessor and that guidelines had been written for people carrying out this responsibility. These covered such matters as the process for conducting reviews, the conduct of interviews and the legal implications for assessors in the event of a critical report. He also said that his experience thus far had confirmed in his mind that it was unlikely that the issues in any investigation would be sufficiently "black and white" to make the outcome of an assessment straightforward, because it would always be a matter of interpretation rather than strict liability. The client for the investigation in this particular case was the employing authority as they had commissioned the review in the light of

the complaint from the consultant. Therefore, the assessor felt that the issue of any sanctions was not a matter for him but the employing authority, although he recognised that his findings and how he presented them would have a major influence. He still had concerns about his own legal liability in the wake of his report and had taken independent legal advice on this issue. He believed that his report would be the first of its kind in relation to a breach of the Code and that, as a result, it may set a precedent for the future. Despite this he also believed that the Code currently lacked professional credibility and was somewhat limited to use whenever there was a suspected breach. He felt that there had been no real debate about the Code in the management community that he was part of and felt that this was likely to be the case elsewhere because there was no impetus for it.

Similarly Code group participants were not able to identify any examples where they had had reason to use the Code, or refer to it, in their own work. One, however, said that the Code reflected his own fundamental values shaped in him from childhood so he saw it as the way he tried to live his life. This was epitomised in the Code requirement for the safety of patients to be the paramount concern and for managers to show respect to others at all times. These were, for him, fundamental tenets although he recognised that his values might not necessarily be shared by all managers. Nevertheless he thought that the Code would "cause managers to think and reflect on what they do believe".

The views of managers

Participants recognised that the Code could be useful to them but felt that this value was somewhat limited. In particular they thought that it might be helpful when there was a specific case where they were unsure what might be expected of them and were seeking guidance as to how they should act. Similarly it was suggested that it could be of help when managers were getting into difficulty and feeling exposed to scrutiny of their actions. Even in such cases, however, participants thought that there were other sources of help and advice that they would be more likely to turn to for guidance than the

Code of Conduct. Most mentioned that they would seek support from a respected colleague, or mentor; in such cases and that the Code would not give them much in the way of comfort or practical guidance. One said that "even with the best will in the world the Code is too broad brush to provide any real help in situations that are inevitably local in their context". She went on to say that in such situations she thought that the framework of local organisational values and her own personal standards and values developed over years of training and practice were the guiding principles as far as she was concerned. However, when asked to elaborate on these, she quoted examples such as respect for others and treating people fairly, which do, in fact, feature in the Code of Conduct.

Managers were also at odds with the Code group members in relation to whether they saw the Code guiding their actions or setting out the qualities that they should possess. One said that it was neither of these, but seemed more like an attempt at a set of standards that would act as a reminder to managers of how they were expected to act. Another was not sure because "it is a bit of a mixed bag" with the emphasis on trying to ensure compliance in such areas as putting the patient first but "still smacked of a politically correct statement". More scepticism was expressed about the Code's contents by another participant who said that, whilst she would like to take at face value the commitment that it recommended that managers should have to openness, she found it "difficult to reconcile with other communications from the centre warning us not to talk publicly about things like financial deficits".

Participants unanimously said that the Code had not been received by managers with any great enthusiasm, nor had it created any real opposition, although one participant said that she was aware from discussions with colleagues in her area that it had been met with annoyance from some who felt that it was" teaching us to suck eggs". Another participant said that, other than the occasion on which it had been discussed in relation to being incorporated into his contract of employment, he had never heard it mentioned in his organisation and he had not felt strongly enough about it to motivate such a discussion.

None of the participants had experienced any training or familiarisation in the Code and how to use it and most had not heard of anything being offered, either nationally or within their own area. One indicated that he was aware that training was being set up for those individuals who were interested in becoming assessors to investigate potential breaches of the Code but that simply confirmed for him that "the whole emphasis is on compliance not development". His view was that for the Code to be fully adopted out of choice by managers it should feature in appraisal sessions and objectives and be part of "the bloodstream" of manager's personal development. Another participant thought that, although it would have been helpful to have a centrally-run training programme, this would simply have "revealed the flaws in the Code and prompted substantial changes and re-drafts and the reality was that the centre wanted something in place quickly irrespective of whether it was properly thought out and consulted on".

Participants seemed to be less troubled by the requirement for the Code to be incorporated into their contracts of employment than might have been expected. One questioned what legal status incorporation would have and there was a general view that the Code was too imprecise to be enforced by this means with breaches being too difficult to prove and very much open to interpretation. Participants would have much preferred a different route to enforcement with more emphasis on voluntary acceptance and some independent means of assessing possible breaches. However, it was recognised that this path was not open at the moment because of the fact that it pointed the way to professional status and most participants were at best undecided as to whether this was the right way to go. At the present time it had to be accepted that no such mechanisms existed for voluntary adoption and monitoring by the management community. Another participant ventured the opinion that the extent to which the Code is adopted will depend on whether it reinforces local needs, in terms of chiming in with the expectations of managers at local level. Otherwise he thought that enforcement would only come in the light of a body of case law relating to investigation of possible breaches. This emphasis on the overriding importance of local values was

shared by another participant who said that these would always be the more powerful influence on the behaviour of managers particularly where the organisation has committed itself publicly to such values. Her view was that these values were inevitably "closer to home" and were more easily accessed by staff, patients, partner organisations and the public and would be much more likely, both to be used and taken notice of, in holding the manager to account for any breaches.

The limitations of the Code

The views of the members of the code group

The majority of the participants said that they were realistic about the value of the Code, believing as one said, that "it is simply about us as managers being explicit about what we believe in and clarifying a set of behaviours that I feel reflect the way that we do generally act". There was recognition that the Code may not be able to address some of the issues that concerned them as individuals about inappropriate management behaviour, such as bullying and discrimination, with one person saying "I am not naive enough to believe that the Code can change that, certainly not in the short term anyway". Most participants acknowledged that it would make little fundamental difference if there were no code, but reverted to the pragmatic response that "something would have been needed in the wake of Kennedy". Others, also in pragmatic mode, said that "not having a code for a group that should be pursuing professional or chartered status is not an option". Nonetheless, there was a general view that managers would be less likely to do the "right thing" if there were no code so, to that extent, it had made a contribution, however modest.

Despite this, there was reticence to claim any real impact for the Code so far, although one participant said that it had changed the relationships at national level with the doctors, for example, in discussions between the representatives of managers and employing organisations with the medical profession "because they now see us as having greater legitimacy". The general view, though, from Code group members was that the Code's main

impact would be longer term with the hope that it would be the first step in providing a more professional framework for managers in the future. This led most participants to speculate on how the impact of the Code would be viewed in the future. The answers showed that most people hoped that it will have been accepted by managers as a practical guide in helping them to deal with ethical dilemmas, and, also, that it will have been seen as a positive contribution to working on an equal footing with other NHS professions. One note of dissent from this positive vision came from someone who feared that the Code would be seen merely as a "hygiene exercise, clearing up some untidy mess for the NHS Executive".

The Code group members were blunt and straightforward in their views about the limitations of the Code – one saying that "it is just a set of words – it is not going to make managers behave fundamentally differently". Another said that "it lacks the teeth that a professional code would have and it is therefore not the finished article. My worry is that it was commissioned and devised to meet a very specific requirement but the way it has been launched takes it way beyond that into disciplinary territory and it may not be fit for that purpose". In a similar vein, another participant said that his concern was that nobody was doing anything to promote it in any positive way, and that he would like to see a "structured programme of training and familiarisation to help managers to see how the Code could help them and be in their best interests. My fear is that it will only be used when there is a suspected breach". Others shared this fear and felt that more emphasis should have been put on training and regional events to discuss and debate the Code in open forum with managers.

The views of managers

The main question for managers in assessing the value of the Code seemed to be related to the issue of whether the Code was seen to meet a local need, either by managers or their organisations, and the responses seemed to indicate that it did not. One manager typified this response by saying that "the Code is not sufficiently sensitive to local needs – it's too broad brush to be useful". Another went so far as to say that the publication of the Code evoked

the response from most managers that he knew of, "well, fancy that!" However, on reflection the same manager said that he could see that it could be useful to assess the extent of any wrongdoing when a chief executive "had gone off the rails", although otherwise he could not see it being referred to very often.

The attitude of managers towards the Code seemed to vary between being open-minded about it as a basic set of standards, and being suspicious or dismissive about its value to them personally. In this latter mode, one manager said that the Code had never been referred to either in his trust or within the management community that he was part of. When asked if it had now been incorporated in his contract and if it had been discussed at that time, he confirmed that it was now in his contract but that neither he nor his chairman felt that it needed any further discussion. The fundamental problem with the Code in the eyes of the participants was that it was unclear to them how the Code was to be used and enforced. One said that codes could only be relevant in the context of a profession where there was acceptance by the members of that profession of the standards it set and an independent means of monitoring compliance and investigating breaches. Another commented that it would have had much greater significance if the emphasis had been on the Code as a development tool for managers backed by a systematic programme of training and support. A different view was also expressed that the Code may, by its very existence, prompt more debate about what the role and responsibilities of managers should be and that its perceived inadequacy may lead to improved versions being introduced by managers at local level or by communities of managers devising something that they believed to be a closer articulation of what they should be held accountable for.

There were also real concerns amongst the managers about the process adopted for the issue of the Code. Principally these seemed to be related to the lack of any campaign to launch it and to highlight its significance and value to the management community and the NHS at large. As a result it was felt that the Code had not become embedded either with the managers or with other groups of NHS staff, let alone patients and the public. One respondent

said that she did not feel "engaged with the process and, therefore, the product itself and this meant that it was treated at best with indifference and, in many quarters, with suspicion". This was reinforced by the fact as she saw it that "the only post-launch priority for the centre has been about training people to investigate breaches, which probably proves where they are coming from". Another participant reverted to the argument about whether management is a profession to explain the central limitation of the Code by saying that "because management is not a profession there is neither the machinery for enforcement nor the ownership and good will of the community of managers to make it work on a voluntary basis".

The future development of the Code

The views of Code group members

Participants were unanimously of the view that there should have been a centrally-run training programme to support the introduction of the Code and were disappointed that this had not been taken forward to date. Most members had spoken about the Code in settings where managers were present but no-one seemed to see themselves as ambassadors for it, believing that this was a role for the NHS Chief Executive or his appointee and that, as there had been no indication that he wanted to take this up, there was little else that anyone could do. Most participants felt that the move to identify and train managers to act as assessors to investigate possible breaches of the Code was appropriate and necessary and some saw it as vital that this was being done under the leadership of a representative body in the shape of the NHS Confederation, rather than the Department of Health. There was also a recognition that the Code was, as one participant put it, "a work in progress that would need to be re-visited and revised over time and in the light of further changes because we are all well aware that the Code itself was a response to a point-in-time issue".

There was some reticence about evaluating the Code because, as one person put it "it may be a bit early to do that and, anyway, because it is

primarily about symbolism, how do you evaluate symbolism?" Several participants said that they hoped the Code would be developed as a tool to protect managers and to raise the standards of management behaviour in the future. One said that this would be greatly aided by "the establishment of a professional framework with a standards committee or a performance committee to oversee the standards in action". Another participant said that he felt that there should be a formal review by the NHS Executive three years after publication and that this should be a norm for the future.

The views of managers

Despite their strong views about the limitations of the Code, most managers saw the Code having some significance in the future sharing the view of the Code group participant who had suggested that the main challenge to a binding set of values and standards amongst managers would come with the advent of more private sector involvement in the NHS and the move towards Foundation Trusts, which the government was encouraging to give greater local ownership and autonomy to NHS organisations. It was felt that this would inevitably call into question whether traditional public sector values would survive this shift in government policies and priorities. In such circumstances some participants suggested that the Code might provide a "touchstone" to measure this shift although most felt that it would be the Code itself that would have to be adapted in the event of any perceived clash with the emerging changes, not the other way round.

Managers also were of the view that any review of the Code should take account of the deficiencies, as they saw them, of the process for the development of the Code in the first place by seeking more active participation from the management community and forging a stronger bond with people in the field. As one participant put it "next time the process has to look out towards the NHS, not simply up to the NHS Chief Executive and Ministers". There was, however, unanimity that there should be a "next time" for the Code of Conduct and this was borne out by a comment that "at the end

of the day if it improves public accountability it has to be in everyone's interests".

A medical viewpoint on codes

Throughout my research the links between the initiative to produce a Code of Conduct for managers and the existing, and in some cases, long-standing codes that govern medical practitioners have been both prominent and regularly emphasised. Indeed one of the stated aims for the Code was to place managers on an equal footing with other NHS professions.

Bearing this in mind I felt that it was important to include in my research an independent informed source of opinion about the development and use of codes in recent years by, and for, the medical profession, to see how far these experiences seemed to have been taken into account in the production of the managers' Code and what findings I could arrive at that were relevant to this analysis. I therefore approached a former senior figure in the medical profession who had been involved at the top level in formulating the guidance for medical practitioners over the past decade and was intimately familiar with the history of codes in medical practice. He also had worked closely with both managers and politicians during his career and could offer a perspective on how far managers could draw worthwhile and appropriate parallels to what had happened with doctors. What follows is an account of the discussion that took place.

By way of background the participant was a member of the General Medical Council at the time that the Guide to Good Medical Practice (GMP) was drawn up and also was a senior figure in the NHS. The GMP was widely seen as the model for the Code of Conduct for managers although some aspects of this model were seen in some quarters as too restrictive for managers. Perhaps the most striking difference between the GMP and the Code of Conduct for managers was mentioned at the outset of my interview when the participant pointed out that the GMP had been drawn up, not by the government or the NHS, but by the medical profession itself. Indeed there had been recognition

from all parties, including government, that the GMP had to be driven by the profession if it was to be accepted by doctors. The alternative of a government led process would, as the participant put it "have killed it stone dead".

The hope, in terms of what the GMP could achieve, was to "provide a basic statement of what doctors see themselves doing, for both the individual clinician and for the profession as a whole". It was also intended as "an explicit set of standards that the profession itself had agreed to adopt following a very lengthy and, at times, difficult consultation process". The purpose was to provide both a set of general principles to guide how doctors should act and to set out the qualities that doctors should possess. Perhaps the most important aspect, though, for this participant was in the training and education agenda that the GMP set out for the future. He commented that this was "a new dimension and was there to be used by university medical schools to set a revised curriculum for the future education and training of doctors. What's more, universities had to act on this because they knew that future inspection visits would look for evidence that they were building this requirement in". He went on to say that "this has raised awareness that these things do matter and the follow-through on the education side has ensured that the profession has taken the GMP seriously".

In terms of the implications of the GMP for healthcare management decisions, this participant felt that the most significant area where it would have influence would be on rationing decisions. Although he thought that "no laid-down code or procedure could cover every rationing decision that might arise because these will always have to be judged on the circumstances of each case", the GMP did give procedural guidance as to how doctors should act in such circumstances and this could be useful to managers and doctors alike in scenario planning or case study work to either predict or review doctors actions. The participant went on to say that the GMP gave managers a framework within which to understand the bounds of professional conduct for doctors and how they are expected to function by their professional body. As

such he felt that "managers could use it to integrate doctors within the organisation and to foster teamwork between doctors and managers".

In these circumstances did he believe that a separate Code of Conduct was required for managers? He responded by saying that "maybe there should be a generic code for all NHS staff, a sort of statement of shared beliefs backed by a set of organisational values for each NHS organisation". Whether a separate set was then required for managers depended in his eyes on whether managers saw themselves as professionals in the accepted sense of the word. He believed that situations that call for value judgements to be made rather than simply following a policy or procedure may raise that activity to a professional level and, if managers saw themselves doing that, to his mind, they needed a separate code. In so far as the future for the GMP and the Code of Conduct for managers was concerned, this participant thought that an important area that had not yet been properly addressed was the need to make the public aware that these policies existed and what their purpose was. Although he felt that it was not a good idea to be frequently revising such policies, he also thought that it would be important to ensure that there was greater public involvement in their revision in the future.

The limitations, as he saw them, of both the GMP and the Code of Conduct were related to the issue of dealing with population-based decisions about entitlement to healthcare and the importance of recognising that no Code can cover every eventuality and that, if there were internal inconsistencies between the GMP and the Code of Conduct, these would not be resolved by producing more codes. Finally he thought that codes were an inevitable part of professional life and that, if there were no codes "somebody would immediately sit down and write them because it is the natural and well-trodden route for any profession".

I shall return to the relationship between the development of codes for the medical profession and their significance for the Code of Conduct for managers in my analysis in Chapter 7, but, at this stage, it is worth recording that there were three important findings from this interview:

1. That the GMP was commissioned by the profession not by the NHSE/Department of Health and all parties recognised that this was crucial in securing the commitment of the profession
2. That the process was notable for a long and intensive period of consultation with the profession and that this was significant in gaining ownership of the final outcome
3. That there was a strong emphasis on the education and training required to familiarise doctors with the GMP, backed up by the encouragement and monitoring of medical schools to ensure that the GMP features highly in their curricula for doctors in training

Summary

This chapter sets out the responses of the Code group members and the managers in the field to questions posed in a series of interviews about the background, purpose, application, limitations and future development of the Code. It also includes the result of an interview with a senior figure from the medical profession showing how doctors have approached the development of Codes.

The interviews show that Code group members and managers recognise that the Kennedy report was the main motivating force for the Code of Conduct. However, whilst Code group members believe that other factors were important such as the need to provide some protection for managers from inappropriate political demands or to provide parity with NHS professions such as doctors; managers are sceptical about this with most believing that the Code was designed primarily to provide a further mechanism to monitor and police their actions.

Similarly, whilst Code group members thought that the Code was intended to provide a guide for managers as to how to act in difficult ethical cases, managers did not see it as giving them any real help in this area believing that it was too generalised to be of use in local situations and that, if they were in

doubt about how to act in such situations, they would be likely to turn to other sources of advice rather than the Code.

Code group members generally hoped that the Code would be used when managers were dealing with significant changes, such as the advent of Foundation Trusts, but managers felt that it would need substantial revision to be of use in such situations. These are examples of the differences in views about how the Code might be used with the Code group members being more optimistic and managers less so, or, in some cases, often veering towards a dismissive or pessimistic view.

Both Code group members and managers shared disappointment about how the Code had been introduced and the lack of any systematic approach to training and familiarisation. This was seen by the Code group members as hampering the understanding of how the Code could have a positive impact for managers and by managers as a missed opportunity for debate about how to reconcile the demands and pressures placed upon them. The experience of how the medical profession handled the production of the Guide to Good Medical Practice served to emphasise the differences in the process particularly in relation to consultation and training.

CHAPTER 6

THE CASE STUDY

Introduction

In the introduction to this thesis I raised a question about whether the Code of Conduct is seen to be useful to managers in their day-to-day work and in the process of management decision-making. The purpose in carrying out a case study was, therefore, to look at a real-life example of management decision-making on a major change in NHS service provision to establish how that decision was arrived at in practice and what values and principles were adopted by the managers to inform the process. Specifically also to establish how far, if at all, the Code of Conduct was applied as part of the process and whether it was seen to be useful by the managers involved.

The aim is then to consider the findings in conjunction with the findings from the interviews with members of the Code group and managers in the field to arrive at conclusions on the central questions for this study relating to whether the Code is fulfilling the aims and aspirations of its architects and proving to be useful to managers in guiding and setting standards for their work.

Context

One of the key areas of decision-making that NHS managers have to deal with relates to the implementation and management of significant changes in healthcare provision, for example the closure of a service or the centralisation of services on a major hospital site. Often such changes are controversial, either with service providers or users or both, and they also can raise wider public concerns. On the other hand, service change is necessary if the service is to adapt to changes in technology and rising expectations on the part of patients, politicians and the public. In such circumstances managers are expected to manage significant change whilst also 'keeping everybody on

board'. Usually such decisions, whilst being based on either clinical evidence or best use of resources, or sometimes a combination of both, fall to managers or management boards because increasingly this has been seen to be the province and responsibility of managers rather than professionals, who may have conflicts of loyalty when it comes to issues of what is best for a community of interests and individual patients. In my experience as a former chief executive it is precisely in these sorts of circumstances that managers need to have some understanding of the principles on which such decisions are being made, and particularly what their own principles are in approaching such issues. I have therefore sought to identify one such area of decision-making for this case study.

The particular context was an exercise carried out by a Primary Care NHS Trust (PCT) to change the location of rehabilitation services from a community hospital to the nearest district general hospital. This change was based on clear evidence that the appropriate skilled staff and related equipment and support services could no longer be provided to meet the required standards in a community hospital setting. Because this constituted a significant change of service for those users who would now have to travel to the new location it was necessary for the PCT to carry out a formal consultation on the proposed changes which included consultation with the public amongst other interested parties. The proposal was potentially controversial because it could be seen to be harmful to a small group of patients but the rationale was that the service could be better provided in a large hospital setting and that this constituted better use of scarce resources, both financial and human.

My interest was to explore with the PCT managers what values had informed their approach to this exercise, how they had arrived at their decision following the consultation, and what part the Code of Conduct had played in their thoughts and actions. Arguably, given one of the stated aims for the Code – that it would provide guidance for managers in their decision-making – and the fact that this sort of issue is perhaps typical of those that involve multiple constituencies and the need to reconcile different needs – one might

expect that the Code, or some other set of values, would have some prominence for managers facing such decisions.

Methodology

As part of the background to this case study I was given access to copies of relevant documents about the proposals, including the document setting out the changes for public consultation. In addition I obtained copies of the PCT's Strategic Framework for 2003 – 2008 entitled 'Looking Ahead', and the minutes of meetings relating to the issue and the decision of the PCT board to consult the public. I was also given a copy of the draft resolution of the Scrutiny of Health Services Committee of the local authority relating to this exercise. This committee had formal responsibility for overseeing the consultation process to ensure that it met the appropriate national and local standards.

Semi-structured interviews were then carried out with the Chief Executive and other relevant managers involved in the process. This raised an important issue that seemed to have implications both for this study and maybe also for the applicability of the Code of Conduct itself. This related to the question as to who actually should be included in any study looking at management decision-making at this level in the NHS. Clearly the executive managers would fall into this category but what about the appointed chairs and non-executive directors of the NHS boards? By one definition these individuals were there to scrutinise the work of the executives but they also clearly had a role in deciding priorities and the use of resources through setting budgets and approving strategies and plans. Surely this meant that they were, at least in the case of issues that came before them, significant players in the decision-making process? Also it was clear that the chair and the non-executive directors had a role in terms of the Code of Conduct to monitor the activities of the chief executive and executive directors, to ensure that the Code featured in the executives' employment contracts and to report any concerns that they may have in relation to the executives not complying with the Code.

Given that in this particular case there was no argument that the board had been intimately involved in the decision-making, as evidenced in the reports and minutes of their meetings, and the responsibilities that they had in relation to the Code in so far as their executives were concerned, it seemed entirely appropriate to interview non-executive members of the board as well as executives as part of this study. As a result I interviewed two executive members of the board, including the chief executive, and two non-executive members, including the chairman. The questions posed in the semi-structured interviews were designed to elicit responses about the ethical principles that the PCT adopted how far external guidance was useful and to what extent their own values were important in the process (a copy of the questionnaire used is attached at Appendix 4).

It was important to clarify for all participants that I was not in any way reviewing or forming judgments about either their decision-making process or the merits or otherwise of the decision they reached. Rather the focus was on the values and principles that had underpinned the process and the part, if any, that the Code of Conduct had played in their thinking and actions.

The findings

The document search

By and large the document search revealed that the PCT had adopted best practice in terms of the process it had put in place for carrying out the consultation exercise, and this was confirmed by the Scrutiny Committee for Health Services of the local authority which commented on the fact that the PCT had shown "openness and understanding in its approach to explaining and taking into account the views expressed by the Committee and local people during the consultation". This of itself showed that the PCT was adopting, at least, the spirit of aspects of the Code of Conduct in terms of openness and willingness to work closely with other partners.

However, the documents also revealed that the PCT had initially been alerted to the possible changes in service provision at the community hospital by the current provider of those services, a local hospital trust, saying that it would be necessary to close the rehabilitation unit on cost grounds because it was no longer viable and making this known through the pages of a local paper. This perhaps indicated that there were different values motivating the hospitals trust with financial viability featuring near the top of their list. Indeed one of the documents indicated that the hospitals trust was quite prepared to keep the unit open if the PCT provided more money for it to continue. In essence, therefore, the PCT had been put in a position where it had to make a choice; it could either accept that the unit should close, keep it open by providing more money or arrive at some other strategy that would meet its strategic aims and its own principles and values.

The report prepared for the PCT board, and the document used for the consultation exercise, showed that it was committed to finding a way forward that recognised that alternative provision would need to be made for the rehabilitation service but that the PCT did not see this as signalling the impending closure of the community hospital as it was committed to retaining it and finding alternative ways of providing appropriate services there that met the wider needs of the community. The detailed proposals as to how the facility would be used in the future would be the subject of further discussion and consultation that the PCT promised to undertake with all interested parties over the next few months.

Perhaps the most significant document made available was the Strategic Framework for 2003 – 2008 which incorporated a clear statement of the PCT's overall aims:

- To put the health and related needs of the patients, users, carers and members of the public at the centre of everything it does
- To value and support all staff, working in partnership with them to ensure a learning culture

- To be an organisation which seeks continuous improvement based on best practice.

More importantly, for the purposes of this study, it also included a set of values underpinning how the PCT would work in pursuing the above aims. These are set out here:

- *Be patient, user, carer and public-focussed*
- *Be professional, credible and accountable*
- *Be realistic, decisive and focussed*
- *Be approachable and courteous at all times*
- *Encourage and respond to feedback from service users and staff*
- *Listen and respond appropriately*
- *Be open and honest, sharing clear, timely and relevant information*
- *Be inclusive involving staff in decisions which affect them and in improving services*
- *Reflect and review practices, sharing learning and making changes when desirable*
- *Learn from errors, be proactive and adopt a just and equitable approach*
- *Seek out and share research best practice and evidence*
- *Promote and support creativity and innovation*
- *Encourage informed and managed risk*
- *Maximise opportunities to modernise services*
- *Invest in staff and organisational development when relevant and appropriate*
- *As far as reasonably practicable, ensure safe premises*
- *Secure value for money and financial balance*

The significance of these values, or ways of working, and the purpose in including them here is that the board papers indicate that the fact that the PCT had recently committed itself publicly to these meant that they had to,

not simply use them in their approach to the exercise for rehabilitation services at the community hospital, but also be *seen* to be using them.

The interviews

In order to provide some structure for the findings from the interviews the responses given by the participants are grouped under headings relating to the following questions:

- Does the PCT have a set of ethical principles that are applied in cases of this type, and, if so, were they useful in this case?
- Was the NHS Code of Conduct for Managers used in this case and how useful do you think it is?
- How far was external guidance useful in this case?
- Would you be happy for the process adopted for this case to be used as a precedent for the future?
- Were your own values compromised at any stage through this process and what pressures were you under?
- In hindsight do you think that anything could have been done differently?

Local ethical principles

All participants confirmed that the Looking Ahead document containing the statement of values set out above had ownership from board members and that they had been mindful of those throughout this exercise. The chief executive indicated that she had checked the actions of the board and her managers against these values and believed that they had kept their promises, particularly in relation to being open and "prepared to go the extra mile to listen". All participants believed that the most important factor in ensuring the PCT's position was soundly based, was showing that they were open to the views of others and that they would take these into account. This was felt to be particularly important as the current providers of the service had

raised the concerns of local people by threatening to close the service without full consultation. As a result the PCT felt that there was some ground to be made up for the NHS as a body to regain the trust of local people. This was seen to be at least as important as the outcome of the consultation on the future of the unit because it would prejudice any future dealings between the PCT and local people. One participant summed this up by saying "we devised the values set out in 'Looking Ahead' and the most important for me were openness and public involvement so if we weren't prepared to stand up and be counted on these we might as well have packed our tent".

However, there was a feeling that the duty of openness did not extend to debating in public the differences of view between the PCT and the hospitals trust. This was seen by all participants as showing the NHS as a body in a bad light and potentially confusing local people about the issues. One participant said "we should be standing 'four square' on these issues. I happen to be fully in support of community hospitals but even if you're not it would bring us all into disrepute to be arguing about it in public".

The use of the Code of Conduct for NHS managers

All participants confirmed that the Code of Conduct was not referred to in this case and only two had knowledge of it, although it had been incorporated into the chief executive's contract of employment. Those who knew of it said that they were sceptical about its value because it was seen in the management community as "an exercise in covering people's backs at the centre". This served to indicate that, whilst the specific instructions about the incorporation of the code into the chief executive's contract of employment had been followed, there was little interest in it, even amongst those who were aware of it. This lack of knowledge or enthusiasm may be a manifestation of the general suspicion or disinterest in the Code in the wider community of NHS managers which was evidenced in the findings set out in Chapter 5 and which was certainly shared by the chief executive of the PCT. As a result it seems that, in this case, very little discussion took place at board level on the use and application of the Code. Without a full understanding of the Code and its

requirements in terms of standards of management behaviour, it begs the question as to how those board members could exercise the monitoring role set out for them as part of the purpose of incorporating the Code into the contracts of employment of their executives. In the views of the participants the answer seemed to reside in the confidence that they expressed in the robustness of their own set of values and an inherent belief that their responsibilities in terms of holding executives to account for their behaviour could be readily discharged by reference to this set of values and other measures of good governance, without recourse to the Code of Conduct.

Whilst everyone felt that clear principles were necessary for a public organisation to be held accountable, the Code of Conduct was not seen as anything more than "a tick-in-the-box exercise for the NHS executive" that would never be able to achieve the ownership that a local code or set of values, such as the one that the PCT had developed, would be able to attain. When drawn to their attention in discussion, though, most participants agreed that it could be said that there was significant overlap between the Code of Conduct and the PCT's own values. However, one participant pointed out that "the difference is we chose ours".

The value of external guidance

There were mixed views about the value of external codes in general, with one person saying that information issued by the Appointments Commission, (the national body responsible for overseeing appointments to public boards and authorities), had been useful in setting out what was expected of board members and the standards they should uphold, whilst another said that, "rather than applying central guidelines, ethics for me is all about handling sensitive issues well, understanding what is possible and getting people involved and hearing their point of view". One board member commented that they "did not feel that there was any need for external guidance – all the board members were experienced in their own fields and that, coupled with our own set of values, was enough to make a judgement in this case". This

resembles the view expressed by members of the Code of Conduct group who indicated that they felt no need of outside help in devising the Code.

Another view, from a participant with a medical background, was that, rather than having to refer to guidance or external advice, "it was much more important that the leaders of the organisation possess personal moral standards that they demonstrate in everything they do". When asked to expand on this he cited a real belief and passion to improve services, being truthful and not wasting valuable resources as being important examples of the sort of standards he had in mind. These echo to some extent the views of Loughlin, referred to in Chapter 3, who argued that managers need human qualities, such as humility, and an understanding of moral issues, neither of which can be implanted by the imposition of values through a code, but rather requires immersion in the issues through education and training.

The use of this process as a precedent

All participants said that generally they felt the process had worked well and that the feedback from the small group of users of this service was that the PCT had tried to stick to what they said they would do. The Scrutiny Committee had also been complimentary about the way that the PCT had handled the process. All participants, however, felt that the part of the process that they would not want to repeat was the way that the hospitals trust had started the public discussion by announcing that the unit would have to close. This made things particularly difficult with the users of the service at the outset, although in time the PCT was able to establish a measure of trust with them. This highlights the importance of the process and procedures in such cases. As indicated by Daniels and Sabin and by Hunter, also referred to in Chapter 3, there may often be no inherently right answers in these cases relating to entitlement to treatment, or, as in this case, access to services, but the process needs to be seen to be fair and open. The earlier stance of the hospitals trust had been seen implicitly as a betrayal of this requirement.

Similarly, all participants felt that the exercise had helped to cement the view amongst partner organisations that the PCT was fair-minded in its approach and would, as one person said, "stick to our guns in terms of what we believe to be right". In that sense "the exercise had been invaluable in building trust and proving that we will act in accordance with our principles".

The role of personal values in this process

The chief executive said that she had felt particularly pressurised at the outset by what she perceived as a clear difference in values between her organisation and the hospitals trust, and the chief executive of that organisation in particular. At the time she was angered by his insistence that the issue for him was straightforward; either the PCT came up with the money to keep the unit open or he, as the accountable officer for his organisation had no choice but to close the unit because it was uneconomic. In retrospect she now felt that "it is getting more difficult to say whose values are right. The pressure to balance the books is greater than ever and there would be no chance of the hospitals trust becoming a foundation trust if they didn't find ways of reducing expenditure. So I can see where he was coming from and I think that there is going to be a real problem in reconciling our values with those of the hospital organisations around us as they all begin to compete for business" The solution as she saw it was "not to pretend that there is 'one size to fit all' but to accept that there will be differences in what drives us in the future and look for ways locally to reconcile these differences".

One participant felt that for him the real ethical issues for the PCT had yet to emerge and would come to the fore as it found that it could not afford everything that it wanted to do and may need to cut services to stay within the budget. When asked how this would challenge his personal values he said "I would have no difficulty with it because I believe it would focus our minds on driving out waste and getting better value for money which I believe is why we are here". He went on to say that he saw no conflict between addressing these issues directly and the PCT's own values "because they are about promoting creativity, encouraging risk and securing value for money". He did

suggest, though that some other members of the PCT might not see it this way.

Other participants considered that the process of arriving at the values in the first place had allowed discussion and debate to take place and that they had felt entirely comfortable with the results whilst accepting that they had had to compromise on some things. Their experience of the exercise for the rehabilitation unit had, to their minds, demonstrated the value of their earlier debates and made it much easier to deal with the tensions within the agreed framework. In the words of one participant, "it heightened my resolve that we were doing the right thing and therefore I went into difficult meetings feeling at ease with myself and what we were doing". The fact that the board members had been involved in the production of the values statement and that it was still fairly fresh in their minds was also mentioned as a factor that helped them to reconcile the pressures that they had come under from local influences to keep the unit open at any cost. One participant said that the earlier discussion and formulation of the values made it clear to him that "we have to see the big picture in terms of how to get the best overall results for patients, not simply be community representatives".

The lessons for the future

Only one participant talked about doing anything differently with the rest reiterating that they felt that the process had worked well and could form the basis of similar exercises involving difficult choices about services. Perhaps not surprisingly, the area where one participant felt that things would need to different was that of internal relations with the hospitals trust to prevent any repeat of the perceived early difficulty with their public stance on the future of the unit. The view was that "the key thing we should have done differently was to get the corporate NHS act together before starting to go public. I hope that we will have learned this lesson but I am not sure that the hospitals trust sees it that way. It's not that we don't communicate because a lot of the time we do but we just seem to have different perspectives and values and I think that the foundation trust development will highlight these differences still

further". When pressed on how this can be addressed, the participant thought that there needed to be a "dialogue" between PCTs and hospital trusts aiming to become foundation trusts to improve understanding about each other's position "and to establish ways of acknowledging and working with the different organisational values and imperatives".

Summary

The findings in relation to this case provide one example of how an NHS organisation handled a decision-making exercise in circumstances where the Code of Conduct was intended to be used, at least as a guide for the managers involved. Several points emerged that seem to be worthy of summary here:

1. The Code of Conduct was not used directly at any stage in the process by any of the people that I interviewed
2. The Code had been incorporated into the chief executive's contract of employment
3. The PCT had a locally-devised set of values that it had committed itself to within the organisation and publicly in its local area
4. This set of values was seen by all interviewees as being of particular help in the way they conducted this exercise
5. The local set of values shows some significant overlap with some of the Code of Conduct in terms of the principles that it advocated
6. There was little enthusiasm for the Code of Conduct generally with most participants doubting the value of an externally imposed set of values, which was how the Code was seen
7. Most interviewees saw the clash that had occurred between them and the hospitals trust as a portent of what was likely to happen regularly in the future with hospitals increasingly having to adopt more commercial, entrepreneurial values which would be out of line with the values expressed in the Code of Conduct

Reflections

There are, perhaps, two issues that bear some reflection in relation to this case study that are appropriate to discuss at this stage before embarking on the analysis of all the material from the study in the following chapter. Firstly, to what extent the results from this case study can be related to the results of the research elsewhere, and, secondly, what conclusions can be drawn that are useful for the study as a whole.

The relationship between the case study and the research elsewhere

The evidence quoted in Chapter 3 would seem to confirm that one of the fundamental issues affecting the extent to which any code is likely to be embraced and adopted by those that it is aimed at is the degree of involvement that they have had in its production and content. This certainly seems to have been borne out in this case. The locally produced code was used and found to be helpful by all the interviewees and it was repeatedly said that this was because they had been directly involved in its production. No such ownership was shown for the Code of Conduct. This is perhaps unsurprising given that very few people were directly involved in the production of that document. However, some might argue that it would have been unrealistic to expect that all NHS managers could have had an active involvement given the geographical spread and the numbers of managers involved.

Also, as reported in the findings from the interviews, the members of the Code group saw the overriding imperative for them to be the rapid production of a document responding to the Kennedy Report. This arguably precluded any lengthy or comprehensive consultation process, the like of which was seen by one of the other interviewees as being essential in the process of producing codes or guidelines for the conduct of medical staff. One lesson from the case study, therefore, is that, because the PCT board members and the managers had been directly and intimately involved in the production of the local set of values, they were committed to its use in the case set out above. What is more, they have recently re-visited their values in consultation

with groups of staff to canvass views on whether the values are realistic and how they work in practice. The outcome of the review as stated in their publication of the revised strategic framework was that, "in general, the original values of the PCT are still very much alive throughout the organisation and, in the majority of cases, are integral to team and partnership working". As a result, in this case, both the key requirements of real involvement in production, and full consultation, were met, giving the set of local values a much better chance of being adopted, almost irrespective of its content.

A connected issue seems to be the authorship of the values. The common view amongst those interviewed was that a key factor for them was that they had chosen the values not had them imposed from outside or above. The importance of this is again consistent with evidence elsewhere particularly in relation to the medical profession and, indeed, any other recognised profession where self-regulation, education and training are key elements in the framework. In such cases there has rarely been any question of sets of values governing an established profession being produced by employers. By contrast the Code of Conduct did not benefit from either a small organisation setting, such as a PCT, or a clear professional context, reaching out as it was to the whole management community in the NHS.

For the managers involved in the PCT the fact that the Code had been commissioned and issued by the Department of Health meant that it would be most likely to be used to monitor and regulate performance and punish those who were found to be out of line. In this respect it was regarded as contrasting sharply with the local set of values. Whether this is a fair interpretation is open to debate but my own experience and observation of the NHS in recent years, is that management at the national level has increasingly adopted a 'hands-on' performance management role. This is evidenced, amongst other things, by the explosion over recent years in the numbers of central targets and inspection regimes. Without entering into the debate about whether this approach is justified or appropriate, it might, therefore, be assumed by managers that any initiative from the Department of

Health would have a performance management or compliance motive. This, of itself, did not seem to be the problem with the Code of Conduct for the managers in the PCT, indeed there was recognition that performance management of national policies and standards was entirely appropriate Rather it was the fact that the Code was perceived to be purporting to be something more than that, prescribing norms of behaviour that were inconsistent with how the central body itself habitually acted in their dealings with managers and extending the provisions of the Code into areas that the managers found to be intrusive, stipulating standards of honesty and integrity. Founded or unfounded, all these suspicions seemed to stem from the fact that the Code had been issued by the Department of Health.

Conclusions for the study as a whole

There are perhaps two important conclusions from the case study and these reflections:

- That great care is required in defining the purpose of any code or set of values. In particular it is important to be clear about whether the code is intended as a vales-based or compliance code or a mixture or what the balance is between the two if it is intended to be both. The evidence of this case would suggest that if the balance is tipped towards a value-based approach, as was the case with the PCT set of values, this dictates a need for a much more intensive and consultative process with the whole community of people that it seeks to influence. A compliance based code, by contrast, as indicated in the evidence presented in chapter 3, will often have much more specific aims such as protecting the organisation from scandals or litigation, and such codes are quite often initiated by employers

- That, as well as clarity of purpose, the whole process adopted for the production of a code will be a vital element in securing commitment to its application. This process may even cement the sense of togetherness, belonging and joint accountability within the community

of individuals that the code is seeking to influence as seemed to be the case with the process adopted by the PCT.

CHAPTER 7

ANALYSIS

Introduction

Chapters 5 and 6 recorded my findings from the interviews of the members of the Code group and managers in the field, and the findings from the case study conducted in a Primary Care trust. This chapter proceeds to analyse these findings.

As was stated at the outset, the purpose of the research was threefold:

- to explore the aims and aspirations of those involved in producing the Code,
- to compare the extent to which these are understood and shared by managers in the field,
- to review how far the Code is proving to be influential in guiding the behaviour and actions of managers in practice.

Specifically I wanted to seek answers to certain questions and they form the framework for the analysis of study findings. For ease of reference, the questions were:

- Is the Code seen by its authors and managers as fundamental to the way that managers act?
- When and how is it intended to be used?
- Is it in keeping with the prevailing organisational values and priorities in the NHS as managers perceive them?
- What steps have been taken to introduce the Code since its publication?
- What is the experience of managers in using and applying the Code in practice?

- Is there evidence that the aims and aspirations of the authors of the Code are being met?
- What other factors/values are seen by managers as influential in their decision-making?

The Code's impact on the management function

Before considering the perceptions of the architects of the Code and the managers it is worth returning to the views of the NHS Chief Executive, as stated in the Managing for Excellence document and quoted earlier in the thesis:

"For everyone involved in management the new Code of Conduct very effectively describes the values which underpin the culture"

This, coupled with the importance that he vested in the Code in the preamble to the published version leaves little doubt that, as the commissioner of the Code, he believed that it had a fundamental part to play in how managers should act. This was reinforced by the requirement announced at the time of publication that the Code was to be enforced by incorporation into managers' contracts of employment and, as a first step following publication, by initiating a process for investigating potential breaches. All members of the Code group felt that these were appropriate things to do, believing that it was essential to give the Code some teeth, or in other words, to ensure that it was seen as fundamental because of the sanctions that could result from possible breaches. One member of the group went so far as to say that failure to comply with the standards set out in the Code might mean that the NHS career of the manager concerned was finished and that therefore transgression of the Code was almost the greatest failure that a manager could commit.

This interpretation, were it to be proved to be correct in practice would certainly elevate the Code to a level where it would be difficult to deny that it

had to be seen as fundamental to how managers should act. Indeed one could argue that it would place the Code on a similar footing to the professional codes for nursing and medicine, discussed in Chapter 3, where the ultimate sanction is the removal of the right to practice by the professional body. However, it is by no means clear that the Code could be used in that way in practice. As suggested by one of the managers interviewed, it is perhaps more likely to be used as supporting evidence for disciplinary action, because existing disciplinary procedures are already stringent enough, and , as yet there is no legal precedent for the Code to be used in that way.

However, interviews with the authors of the Code also indicated that, whilst they expressed the hope that the Code would be seen by managers as helping them in the work that they do and guiding them when they are facing difficult ethical choices, they were somewhat more reserved on the issue of how fundamental the Code would prove to be in practice. There were, for example, clear reservations about the extent to which it could change management behaviour. This view is perhaps more realistic than the impression created by the preamble to the published Code from the NHS Chief Executive. Also it is more in line with the findings of other researchers, such as Wainwright and Pattison discussed in Chapter 3, who found that codes cannot be expected to solve all day-to-day issues and neither can they capture all, or even most, that is worth knowing about professional practice.

Managers who responded to the question as to how fundamental the Code was to the way they act were even more inclined than the authors to see it as being of limited significance. Most accepted pragmatically that something was needed in the wake of the Kennedy Report but they had little enthusiasm for the Code of Conduct and felt that it did not have sufficient ownership within the management community. There were doubts about how it could be enforced and a view that it fell between two stools. It was neither a document that was being used to develop managers' skills, competencies and awareness of ethical issues because no attempt had been made to provide training and familiarisation about it; nor was it a standards document that was being rigorously performance managed. As a result managers saw it purely as

a political necessity that they were either indifferent to or felt was not sufficiently sensitive to their needs. At best it was seen by some managers as of potential future value in helping other NHS professionals form a better understanding of the role of managers or as supporting evidence in cases where managers were being accused of wrongdoing. At worst it was seen as something to help the Department of Health to police managerial activity or to provide another means of getting rid of managers whose faces did not fit. Reflecting on the evidence presented in Chapter 3 on the theoretical framework for codes, it may well be that this ambivalence about the Code on the part of managers is a consequence of the fact that the Code is, in effect, an attempt at a compromise between a corporate code and a professional code. The reality, however, is that, having been issued by the employer, at the end of the day it can only be seen by the employees as a management tool.

Inevitably, the Code's architects had views about the Code that owed something to either their own personal beliefs or the constituencies that they represent in their everyday roles, or, indeed a mixture of both. This was most clearly indicated in their different views as to what they saw as the Code's purpose. One might have thought that this had been made clear in the NHS Chief Executive's brief for the task, but most participants had subtle but perhaps significant variations on the theme. One such variation was the view that the Code would in some way enhance the status of managers, either by creating the first step towards establishing NHS management as a profession or by placing NHS managers on an equal footing to their professional colleagues, notably the medical profession. This is perhaps not surprising given that the members of the Code group were either prominent figures in the management community or officials of bodies representing managers, particularly in the light of the benefits that are considered to result from professional status in terms of greater independence, self regulation and increased social standing and credibility.

However, whilst the managers interviewed recognised the implications of a lack of professional status for managers, none of them shared the enthusiasm expressed by some of the Code group members to use the Code to rectify

this position, believing rather that their status was more determined by how they acted on a day-to-day basis and the reputation of their organisations than on a quasi-professional status conferred, in part, by a Code of Conduct. To most managers the issue of professional status was an open question, but there was no sense that a proper debate had taken place on the issue, or that the Code of Conduct could be the vehicle for such a debate. This brings to mind Edgar's view, quoted in Chapter 3, that achieving professional status involves a protracted period of negotiation and debate both within the occupational group and with a wider public and that, only by this means can a specific self-understanding of the occupation and a change in class status be accepted.

There were also differences in views amongst the authors as to whether the Code was intended as a guide for managers or a prescription for how they should act. While one said it was definitely the former, another said it was definitely the latter. A third interviewee said it was both and another believed it was "somewhere between the two". Managers also seemed to be somewhat confused about what the Code was intended to be, beyond the general acceptance that it was a necessary response to the Kennedy Report. As mentioned earlier, the tendency to include both compliance and value-based statements in a code is not atypical of corporate and professional codes elsewhere, but any attempt to enshrine values in a code can be problematic, particularly if these values relate to virtues such as honesty and integrity. Evidence from elsewhere, discussed in Chapter 3, suggests that it is difficult to see how a code can require practitioners to be virtuous because virtuous people will decide for themselves what to do in specific situations and no set of rules can tell us how to act with compassion or courage. This difficulty of specifying virtuous behaviour is perhaps exemplified in the Code of Conduct in the stated principle to be honest and act with integrity which is then developed in the supporting information in terms of not accepting gifts or inducements and protecting NHS resources from fraud and corruption. This seems to be a fairly narrow and instrumental interpretation of honesty and integrity.

The case study highlighted the fact that, even in an organisation where the Code of Conduct was not favourably received and played little if any part in a significant decision-making process, nonetheless many of the sentiments behind the principles in the Code, such as being patient-focussed and open in dealings with staff and the public, had been incorporated in a local code or set of values, albeit using different terminology. This would seem to indicate that some of the values are seen to be important and did, in that case, guide the actions of the managers concerned. The fact that they had baulked at the Code may owe something to it being seen as having been centrally imposed with no adequate process to engage managers in the field to the point where they would see the end product as their own. The earlier literature review in Chapter 3 highlighted the fact that ownership of a code by the people that it was intended to govern was seen to be the most vital factor in whether a code was actually used in practice.

My interview with a member of the medical profession served to highlight the differences between an established profession and NHS management. In the case of an established profession there is no issue about the need for a code of conduct because it is a necessary part of the framework – it goes with the territory, so to speak – and many other consequences naturally flow, such as the education and training programmes to underpin the code in action and the self-regulatory mechanisms to enforce it. Similarly, in the view of this participant, the fact that the Guide to Good Medical Practice was produced by the profession through its representative body was an important factor in giving the document credibility, as was the lengthy consultation process with the profession at large. It is notable that, when circumstances in the form of the Kennedy Report dictated that there was a need for some sort of ethical framework for managers, the initiative had to come from the NHS Executive because there was no single representative voice for managers that could take action on their part, despite the best efforts of bodies such as the Institute of Healthcare Management. This is in striking contrast to the medical profession where significant initiatives to regulate and govern their activities have been channelled through their own professional body despite some external misgivings about this.

The application of the Code

Perhaps the key theme emerging from the interviews with the architects of the Code in relation to how they had thought about how the Code should be used was that they hoped it would be consulted by managers when faced with difficult ethical decisions. One participant felt that it ought to be used in change situations when the issue of private/public sector differences in values has to be addressed and this was a view that also came through in the case study where it was suggested that the different perspectives of the hospitals trust and the PCT could lead to future disagreements that may be damaging to the image of the NHS as an entity. However even the Code group participant was sceptical as to whether the Code would be used in such a situation believing instead that the political pressure would be to adopt different and more entrepreneurial values.

The Code's architects felt that it was also important to recognise that the Code would be used by others as well as managers themselves. Two participants mentioned that the Code had been well received by the NHS professions, particularly the medical profession, and one of the managers said that he had come to realise that his consultant colleagues may find it helpful as a statement of where managers were coming from. Although there was little evidence of the Code being used by patients or members of the public, the fact that the Code had been posted on the NHS website was seen as an indication that this would become increasingly known about and used in the not too distant future. One interviewee particularly mentioned the media as an important barometer of public opinion and said that, in her experience at the public launch of the Code, the questions raised by journalists seemed to indicate that they were split views between those who saw the Code as a stick to beat managers with and those who saw it as an attempt to clarify how managers should act and behave. It must be noted here that the optimism about the Code becoming known and used by the public flies in the face of much of the evidence about other professional codes. The evidence presented in Chapter 3 would suggest that, although codes often talk in terms

of involving the public, there is very rarely any real public involvement in the production or administration of codes and that, for the most part, the public is unaware of the existence of such codes. Even in the few cases where there is public awareness there is little evidence of public knowledge of how to use the code to call people to account. The important message from this evidence is that even awareness, let alone knowledge, cannot be achieved by simple publication.

Strikingly, perhaps, none of the interviewees from the Code group felt that there was any conflict in the Code being used for different purposes by different individuals. In particular they believed that it was entirely appropriate that it should be used by managers to guide their actions but by others to hold managers to account for behaving in accordance with the Code's stipulations. This, again, is not unusual. Returning to the definition by Hussey, quoted in Chapter 3, codes can have a variety of functions, including guidance, regulation, and discipline. However, it is important to understand, as Pattison has argued, that codes as written texts are of little use in themselves without interpretation. This, of itself, is not a straightforward process, often varying according to the person and the situation. So the notion that the Code can fulfil a variety of needs in an unequivocal way is, at least, open to challenge.

Managers were cognizant of this when asked to identify how the Code could be used to help them. One said that "even with the best will in the world the Code is too broad brush to provide any real help in situations that are inevitably local in their context". Two participants said they thought it might be helpful when managers were getting into difficulty and feeling exposed to scrutiny of their actions, but went on to say that there would be other sources of advice and support that they would turn to first if they found themselves in that situation. Most thought that the Code would be most likely to be used when there was an allegation that a manager was in breach of some part of it and that this was entirely in keeping with their assessment of how it was intended to be used by those who issued it. In general, therefore, there was little acceptance that the Code would be of significant help in guiding

managers' actions because, as one put it, "the whole emphasis is on compliance not development".

There was also a feeling amongst managers that, had the intention been to provide some protection for them and to guide their actions, the whole process would have been handled differently with much more emphasis on consultation and familiarisation and less on setting up the machinery for investigating and assessing alleged breaches. For these reasons managers were less disposed to the Code and, possibly as a result, less inclined to see how it might benefit them. This seems to in line with the views of Wainwright and Pattison, referred to in Chapter 3, who asserted that codes, to be accepted, should be the real, espoused and enacted values of many, not just the aspirations of the elite few.

The relationship between the Code and prevailing organisational values and priorities

The review of documents issued by the NHS Chief Executive before and after the Code of Conduct would seem to support the contention that the Code was seen as the embodiment of the desired culture and values for NHS management at that time. Views were divided, though, as to whether the Code accurately reflected the prevailing values and priorities of the time. Clearly the impetus for the Code had largely arisen as a result of a comprehensive investigation into the failures of the NHS in Bristol where, amongst other things, the actions and behaviours of the managers had been found to be out of line with what might reasonably have been expected of them. This of itself provided prima facie evidence that the culture and values needed to change.

In addition the confidence and conviction of the NHS Chief Executive in publishing and commending the Code of Conduct was tempered by a 'get-out' clause which said that in cases where the Code was out of line with central policies or contractual obligations, it should be set aside. This was widely assumed by commentators and managers as being confirmation that the

Code was not a document to be relied on 'on a rainy day', particularly if complying with it meant being out of step with another seemingly more important obligation. The members of the Code group also confirmed that the prevailing culture was out of synchronisation with the Code to the extent that there was evidence that some managers felt that their main responsibility, and indeed the expectation placed on them by politicians and managers at the Department of Health, was to hit all the government targets particularly those relating to finance and waiting times. There was also a belief from one of the Code group members that the Code was necessary to protect managers from 'the tyranny of government targets'. To this extent, therefore, it could be argued that the Code exposed not simply the differences between the desired values and priorities of the Department of Health and management behaviour at that time within the NHS, but also, and perhaps more significantly, between the desired values and priorities of the Department of Health as expressed in the Code and the way that the Department itself behaved in practice. Managers cited examples such as an instruction not to talk publicly about financial deficits as evidence that the Department of Health "was speaking with forked tongue" when it talked about a commitment to openness.

Here, again, there is no lack of evidence about the pitfalls of codes that do not reflect the true values or interests of those who produce them. Freidson, in his authoritative work on professions and professionalism referred to in Chapter 3, had argued that professions, such as medicine, always acted primarily in their own interests rather than for altruistic reasons. Similarly, Wainwright and Pattison, referred to in Chapter 3, asserted that, in so far as the nursing profession was concerned, although the professional body had always maintained that its primary role was the protection of the public not the representation of the profession, there is evidence that the Code of Professional Practice for nurses has not always served the value of preserving the public interest well. This evidence perhaps suggests that producers of codes who do not reflect the reality of the prevailing values in their organisations or professions, are at risk of producing codes that fall into the 'do as I say, not as I do' category.

However, the findings from the case study show that although the Code itself was not used in the decision-making process by the PCT, there was evidence that at least some of the values set out in the Code were mirrored in the PCT's own set of values, although these were independently arrived at and, therefore, 'owned' by the managers involved. Furthermore, since that time their own set of values has been reaffirmed after discussion across the organisation. Therefore it could be argued that the values set out in the Code were, in that case, chiming with the prevailing values in that organisation. Another manager stated that the extent to which the Code is adopted will depend on whether it reinforces local needs in terms of meeting the expectations of managers and others in that setting. The PCT case study would seem to confirm that, in cases where this happens, the values will be adopted albeit not necessarily through the medium of the Code of Conduct.

Another dimension to the question as to whether the code is in tune with the prevailing values is that related to the direction in which the NHS is seen to be moving, with greater emphasis on the use of the private sector in the provision of healthcare and what is perceived by some managers who participated in this study as the importation of more entrepreneurial private sector values. The case study gave a foretaste of what might happen in terms of the tensions that arose between the local hospitals trust managers and the managers at the primary care trust. The increasingly overt encouragement to hospitals to compete with each other for business and the promotion of choice to be exercised by the patient is seen by many as being directly at odds with a set of values centred on partnership working and openness. Managers were pragmatic about this, seeing it as an inevitable trend, but also questioned whether the Code of Conduct could survive in its present form without significant adaptation or a recognition, as suggested by the case study findings that 'one size would not fit all'.

Recently the Department of Health has recognised that there is significant concern amongst those working in the NHS that the advent of NHS Foundation Trusts will break down the values that have been thought to bind the service together and is seeking to reassure people that this will not

happen by taking the initiative to review the codes of practice that currently relate to the various branches of the NHS, including the Code of Conduct for NHS managers, to ensure that they are fit for purpose for the changes that lie ahead. It is not clear yet how this review is to be carried out, but it is further evidence that the Code of Conduct may need to be revised in the not too distant future. This perhaps demonstrates the changing nature of values in practice and highlights the fact that codes cannot be seen as unchanging 'tablets of stone'. There are many, though, who would argue that some of the values set out in the Code are timeless, such as honesty and integrity, and that they should not be changed to cater for a change of structure.

The limitations of the code in practice

Those who commissioned the Code of Conduct, and those involved in producing it, had ambitious aims as to what it could achieve in providing guidance to managers in ethical dilemmas and in setting out how their actions and behaviours should be judged. The research, and particularly the case study, would seem to indicate that the Code had not achieved those aims for many of those interviewed. This, in part, might be explained by the fact that some were confused about its purpose and felt disengaged with the process adopted to produce it. Certainly most of the managers in the field felt that the fact that the only significant action taken by the Department of Health following the publication of the Code had been to initiate a procedure for investigating potential breaches offered ample confirmation to many that the Code was primarily, if not solely, intended to ensure that managers complied with the prescribed forms of behaviour.

It is, therefore, not surprising that the Code in practice got off to a slow start with many managers showing little enthusiasm for it, nor seeing it as fundamental to what they did. This was despite the fact that observance of the Code had to be incorporated in their contracts of employment. Similarly few managers were persuaded that the Code was important as a first step along the road to professional status for managers, although this was one of the stated aims of some of the architects of the Code. Most, though, believed that

the Code would have increasing significance in assessing management behaviour when there was an allegation of wrongdoing. In that respect at least part of the aim for the Code in practice was beginning to be recognised and there was some acceptance that, although at the moment the Code might appear too broad brush to be used in a definitive way in such circumstances, case law might help to rectify that in coming years.

Having said that managers showed little enthusiasm for the Code, neither did they find what was in it either inappropriate or objectionable in any significant way. This may have indicated, as one interviewee from the Code group postulated, 'bland indifference' on their part, or it may have meant that they felt that much of what was in the Code was reasonable or not worth objecting to. This seemed particularly so in the case of some of the managers interviewed who accepted that a document of this type was needed as a statement of what managers were expected to do and how they were expected to act. This perhaps shows that as a compliance document the Code had gone some way towards achieving acceptance, or at least, acquiescence from managers. But no-one seemed to feel particularly passionate about it one way or the other and the fact that it came with the seal of approval from the Department of Health seemed to be both accepted and, at the same time, resented by some of the managers, particularly those interviewed as part of the case study.

Similarly, very few of the people interviewed, either from the members of the Code group or the managers, felt that the Code was likely to be used by managers to inform their everyday work with the consensus being that the Code would be most likely to be activated retrospectively when there were problems with the behaviour of a manager. None of the managers in the field acknowledged that they had used the code and a number said that, other than for purposes of inclusion in their contracts, they had not heard it referred to either in their own organisations or in the management community that they were part of. This seems to indicate that, far from becoming integral, or even prominent, in the thinking of managers, it was largely irrelevant beyond recognition that it may be cited if there were problems. Even the members of

the Code group seemed to be resigned to this being the case although some believed that its significance would grow over time. In practice the evidence for this is as yet difficult to come by.

All of this is not to say that managers have no interest in exploring and clarifying the values that inform their actions. Indeed the case study demonstrates that there is a strong interest in committing managers to a set of values that have been debated and agreed, and publicised to all parties involved and potentially affected by their actions. In the case study the existence of a set of local values seemed to be helpful both in terms of guiding the actions of the managers and in giving others a framework of accountability within which the managers could be assessed. As mentioned earlier, these local values were to some extent similar to those incorporated in the Code of Conduct itself so it has to be significant that the managers involved felt that the Code itself had not been particularly useful to them, yet they were, in some senses, observing what it advocated. Other responses from managers confirmed that they had a keen interest in acting in what they believed was an ethical fashion and being accountable to those that they served, including their local communities, patients and the staff they saw themselves as being responsible for. The Code at the time of the interviews did not appear to have reflected these feelings sufficiently closely to have secured any real ownership in use or commitment for the future from the managers in the field. However, none were opposed to the concept of a code, simply indifferent to the Code of Conduct and generally suspicious of that part of the stated purpose that related to the Code providing guidance and support for managers in difficult ethical situations.

Thus the practical experience of the managers is that, so far, the Code has not been useful as a guide to them in their work in the way that it was intended. Also, practical experience of it being used for the purpose that most managers believe that it was intended, that is to enforce compliance with standards of management behaviour, is as yet limited to one case where the outcome is not yet known. This may provide the first of a body of case law that some believe will strengthen the role and importance of the Code but it

seems unarguable that, even if this proves to be the case, the Code's status will have been elevated by external enforcement rather than the internal and voluntary commitment from managers.

Another feature of the Code and how it was introduced that has had a great influence on the degree of acceptance by the managers interviewed was the lack of any coordinated programme of training and familiarisation for managers in how the Code should be used. This was repeatedly mentioned as being indicative of the priorities that the Department of Health attached to gaining the commitment and understanding from managers for the implementation of the Code and there is no doubt that this contrasted sharply with what might be regarded as best practice from all research into the introduction of codes elsewhere, as referred to earlier in this thesis. Managers have not experienced any leadership from anyone either nationally or locally to champion the Code beyond the initial launch and exhortations in the documentation relating to it.

As was pointed out by some managers this contrasted with the time devoted at management meetings to other key priorities set by the Department of Health, particularly those relating to key 'deliverables' such as central targets. As a result most of the managers had only a limited understanding of some of the thinking behind the Code and the principles involved, and there was little indication that the process that the Code group had gone through and the thinking behind the content of the Code had been properly debated with the management community, or at least those interviewed as part of this study. Frustration with this lack of follow-up to the publication of the Code was also expressed by the members of the Code group who observed a lack of leadership in this area that they felt powerless to change but which they felt had contributed to the indifference with which the Code had been received. Neither was there any practical evidence that the Code had stimulated managers to reflect in any depth on the issue of ethics for them as individuals with most believing that their innate sense of duty developed either during childhood or acquired during their career in the NHS provided their ethical base. The Code, therefore, had not sparked any deeper understanding of

these personal ethics or built on any firm base in terms of formal ethical training during the manager's careers. As such it was viewed as a policy initiative that lacked the necessary management follow up 'to make it work'.

The future expectations for the Code

Most people were modest in their future expectations for the Code. Many felt that it would be developed as a compliance tool and there was no real resentment to this from managers, but there was a sense that the Code would be found wanting as the NHS began to take on more of the private sector values that were seen to be driving much of the government policy for the NHS of the future. In the absence of any clear occupational or professional focus for managers, local organisations were seen to be the context for the development of values and ethics, much as had been the case with the Primary Care Trust in the case study. This was thought to be part of an inevitable move away from the binding values that had held the NHS together despite efforts that would be made to retain some of these principles. Increasingly, managers saw their values being driven by the need for their organisations to operate in the new health services market and were sceptical as to whether the values propounded in the Code would survive the changes. This seemed to manifest itself in a view that the changes would require a much more 'hard-nosed' attitude from managers with the organisational values being increasingly driven by the need to compete as individual businesses and to focus on those services that would bring in income. Very few managers were antagonistic to these developments with some indicating that they might provide the context for greater management freedom and innovation than had been the case in recent years and that these changes would put a premium on the skills of the managers that they felt had been lost in what was seen as a command and control environment for managers now.

The case study showed that for primary care trusts the emphasis in their thinking was on how they responded to the local health needs and their wish to be part of the local network of services for local people. These seemed to be key factors in determining the behaviours and actions that they defined as

their local values and, as mentioned earlier, these did bear some resemblance to the principles in the Code of Conduct. However, as in that case, managers saw a divide emerging between the world of primary care trusts and the foundation trusts and there was a strong feeling that this would lead to a growing difference in values and motivations between the managers working in these organisations. The primary care trust in the case study is meeting this challenge with its local foundation trust by developing what it calls a Code of Conduct between the two organisations which broadly sets out the ways in which the two organisations will work together and negotiate contracts to deliver services for their local population. This is designed to ensure that the two organisations work together in partnership rather than in competition and, whilst it may be motivated to some extent by a wish to avoid embarrassing public disagreements, is essentially a way of exploring and reconciling the different perspectives and values of the two organisations. Perhaps this may provide part of the way forward in terms of the next steps for the Code of Conduct, with business needs and cohesiveness of local services providing the impetus for new understandings about management conduct at local level.

In parallel with the challenge of this change of government policy, or at least acceleration in the implementation of a change towards a business model, the jury is out, so to speak, on whether the aspirations that some people have for the Code of Conduct will be realised. In particular those that see the Code as a step towards NHS management being recognised as a profession suggest that the next moves ought to involve a wider debate within the management community and with the NHS professions about the role of managers and the ethics and values that underpin that role. This, and the desire to underscore the national values of the NHS as it moves into a new era, may be part of the reasoning behind the new initiative to review the codes of practice, including the Code of Conduct, that govern those working in the NHS. However, there is little evidence in practice that the management community is motivated by the need for professional status in the accepted sense of the term and even the Institute of Healthcare Management seems to have been unable to sustain its momentum to use its own code as the basis for a scheme of

continuing professional development for its members. Progress here seems to have been patchy and limited to a few organisations where membership of the Institute has been strong and influential but national take-up has not, as yet, been achieved. In any event it is difficult to see how a representative body, whether it be the Institute or any other national body, has either the credibility or the strength of membership and support from the management community to mount an initiative in this area that would command the attention and commitment of managers to the outcome. This, if anything, seems to have been made even less likely in the minds of managers by the initiative taken by the Department of Health to produce the Code and to see it as something that should be enforced through contracts of employment. This, in effect, has made it an organisational initiative not a professional one.

So the future for the Code of Conduct in terms of the expectations that people have about it is far from clear. On the one hand there are steps being taken by the Department of Health to review the Code in the light of other changes in policy, which may indicate that it has a future in a different form more in keeping with the new organisational climate, but, on the other hand, the attempts to see it as a catalyst for professionalizing NHS management still seem to be mired in the apathetic view that managers have of this and the lack of any real leadership body for managers to generate interest and involvement in the issue. Two things, however, do seem to be clear; firstly that the Code of Conduct is seen as a compliance based Code and there is an expectation that it will be used as such in the future, and, secondly, that there will be a need for managers at local level to discuss how the policy changes impact on their working relationships with each other in the different branches of the NHS and these discussions may in themselves lead to something approaching codes of conduct at local level. Whatever happens there is no expectation that the Code of Conduct will survive in its present form for very long, either because it was intended as a response to a very specific need and has now served its purpose, or because it will evolve to meet new requirements.

Summary

Returning to the original questions set out at the start of this Chapter, this analysis has drawn out some important themes.

Firstly, whilst the aims and aspirations for the Code were clearly set out in the document and the preamble, and these were largely shared by the members of the Code group, the interviews showed that there were ancillary aims where some of the Code group members hoped the Code would also have a benefit, such as the move towards professional status for managers. Most, if not all, of these have so far proved to be ambitious in practice, particularly the intention that the Code could be both a guide and support to managers and be used to hold them to account. In reality the Code is seen by managers largely, if not solely, as something that will be used to hold them to account, in other words a compliance-based code.

Secondly, the process adopted both before and after the publication of the Code did not succeed in winning the hearts and minds of managers. In essence it was consistent with a compliance-based approach and this was how it was experienced by the managers. The history of codes elsewhere has shown that compliance-based codes tend not to attract the same degree of support from those they seek to govern as value-based codes and this may be one of the key reasons why manager 'buy in' to the Code has been slow.

Thirdly, also because of the process adopted and the steps taken since publication, the main application for the code is seen by managers as a retrospective check on management behaviour so they see little use for it in terms of guiding their actions. In fact there is little evidence of it being referred to or consulted, although some of the principles are being incorporated into local codes.

Fourthly, there is evidence that the Code is seen as being potentially out of step with the way that the prevailing values and priorities of the NHS are moving, and this is prompting both national and local initiatives to review the types of codes that might be needed in the future.

CHAPTER 8

CONCLUSIONS

Introduction

The study set out to address three issues:

1. Identify the aims and aspirations of those responsible for the Code of Conduct,
2. Assess whether these are shared and understood by managers
3. Explore how far the Code is proving to be useful in practice.

The material presented in this thesis has involved a review of the background to the NHS Code and the history of codes in general, followed by an account of the findings of the research based on the documentary evidence and interviews with members of the group involved in producing the Code and managers in the field. Also included is the account of a case study to review the application of the Code within an NHS organisation. What follows is a summary of the conclusions reached from the analysis and some final reflections on this material and the work carried out over the course of the study under the following headings:

- The purpose of the Code
- The process adopted for the production of the Code
- NHS management as a profession
- The Code in practice
- The Code and the prevailing values of NHS management
- Ethics and the NHS manager
- Final reflections

The purpose of the Code

The first requirement for any code based on the experience of corporate and professional codes elsewhere is clarity about its purpose. In the case of the NHS Code of Conduct, those involved in its production were broadly in agreement on this. They saw it as being both a guide for NHS managers as to how to act and a statement of the values that managers should possess. The NHS Chief Executive, in publishing the document said that the Code embodied the values of NHS management.

However, in practice managers were sceptical about the stated purpose, believing that the real purpose of the Code was to provide a response to a specific criticism of managers in the Kennedy Report and to ensure that Ministers and the Department of Health had something in place with which to ward off any future criticism of them. Also they saw the Code being used mainly as a compliance document by others to review their actions in the case of problems. As such there was little enthusiasm for the Code and minimal recognition that it could be helpful to them as a guide. In fact managers could conceive of few occasions on which they would be likely to consult the Code. So far as they were concerned, therefore, the stated purpose was unlikely to be achieved.

This key finding suggests that more thought could, and perhaps ought to, have been given to the Code's purpose and how it was likely to be achieved.

The process

Evidence from elsewhere confirms that the process adopted for the production of a code will be all-important in terms of its adoption and acceptance in practice. Insofar as the Code of Conduct was concerned the process adopted was for the NHS Chief Executive to commission a well-respected Chief Executive from the field of NHS management and for him to assemble a group of people representing NHS management bodies to work on the production of the Code. Consultation with managers did take place and the resulting document was delivered to, and then issued by, the NHS Chief Executive. This was very much in keeping with the conventional way of doing

things in NHS management, and was consistent with the method adopted for many other professional codes. However, as has happened with other codes discussed in Chapter 3, the consequence was probably that the Code ended up reflecting the particular interests of those who produced it rather than speaking for managers as a whole .The fact that the Code group members did not feel that they needed to take external advice on codes may also have meant that they were less aware of best practice in relation to the process than they might have been.

The result was that managers in the field did not feel engaged with the process and did not express any ownership of the outcome. Whilst they had no problems with the membership of the group, they felt that the process had been designed to produce the product that those who commissioned it were looking for rather than something that had real commitment from the management community as a whole. This may have been acceptable to managers if the purpose had been to produce a Code for compliance reasons only, but a code that also purported to be a guide and a statement of values for managers would have needed real engagement and involvement from the field to have any chance of voluntary adoption.

Such an approach usually has to have the express consent of the membership of the body of people that the code is aimed at and the process has to ensure their involvement at every stage. It would be unlikely that such an approach could come best from an employer because they would be seen to have vested interests. The example of the medical profession might have provided a guide to what would have been needed if the aim had been to produce a code that had the commitment of the management community as a whole. In reality, however, this would have meant a more intensive and lengthy consultation process which would have been at odds with one of the key obligations placed on the Code group to produce a document in a short timescale.

It may be concluded from this that, had the purpose been as stated to produce a code that reflected both values and compliance, the process would

have needed to be significantly different to that adopted for the Code of Conduct. Alternatively if the essence was that the process had to deliver a compliance code to the NHS Chief Executive in a short space of time, the stated purpose should have been more restricted. What resulted from the approach that was taken was seen by managers to be neither one thing nor the other.

NHS management as a profession

It is impossible to research the Code of Conduct without encountering the debate as to whether NHS management is a profession and should have professional status. There can be little doubt that NHS management does not meet the accepted tests for a profession at present, such as a process for self regulation, a distinctive knowledge base and a special relationship with those that it serves, but there are many who would argue that this should be the aim. Indeed some of those involved in the production of the Code saw it as a means to this end and representative bodies like the Institute of Healthcare Management have pursued this goal through their membership activities, partly in the belief that it is inappropriate for those managing other professions not to have their own professional standards. At this point, however, it has to be said that the Institute's declining membership over the last decade and its attendant loss of influence has greatly hampered its ambitions in this regard.

There is, however, no consensus within NHS management that professional status should be pursued or that management lends itself to the same sort of framework that denotes professions or is the hallmark of professional status elsewhere. This is significant in relation to the Code because it means that for as long as this ambivalence persists, the central place that a code occupies in the identity of a profession cannot be said to apply to NHS management. There has to be some other reason for having a code. Also the increasingly diverse background and training of managers in the NHS means that there is no clear focus for leadership of those involved in the activity. As a result there is no single body that can legitimately speak on behalf of the whole management community if, as was the case with the Code's origins, external

circumstances or forces call for change. Inevitably, therefore, the initiative has to be taken by the employer but any attempt by the employer to try to prescribe the values and behaviours of the employees, particularly in areas which might be interpreted as personal moral standards, will also potentially be viewed as inappropriate or illegitimate and may result in apathy or disenchantment. This seemed to be the case for managers in relation to the Code of Conduct.

The Code in practice

The most striking thing about the way that the Code was introduced was the absence of any coordinated approach to training and familiarisation for managers as to how it should be used. The result is that, other than it being referred to briefly in meetings of managers at the time of issue and for the purpose of incorporating it into their contracts of employment, there has been little if any debate about the Code and its use and application. The failure to provide a training programme was lamented by the members of the Code group and another example of the process for the Code of Conduct being out of step with what is recognised as best practice for codes elsewhere. Managers also felt that familiarisation and training would have given them the chance to raise their concerns about the Code, how it might affect them and the way they were expected to act in given situations. It is hard not to agree with their conclusions that the lack of any such initiative from those who commissioned the Code was indicative that they did not see familiarisation and training for managers as a priority. This conclusion is further justified by the time and attention that has been devoted to the establishment of a process for the identification and training of assessors to investigate potential breaches of the Code, rather than the training of those who have to use it.

The explanation given by members of the Code group for the lack of a training programme was that such an initiative could only be taken by the Department of Health because they had commissioned the Code and were responsible for the way it was introduced. However, it is not clear whether the importance of training was made known to them at the time. What is clear is that to date no

initiative has been taken by anybody to set up any training for managers in what was claimed to be a fundamental guide to how they should act as managers. The question, therefore, is how was this supposed to happen?

In contrast, the medical profession has recognised that for doctors to absorb and integrate the Guide to Good Medical Practice into their way of functioning as doctors requires education and training initiatives for practicing doctors and those in training. Commentators and authors, referred to in this research, have argued that ethics and values need to form part of the training of practitioners at an early stage rather than relying on the introduction of documents like codes to change the way that people think and behave. So there is no shortage of evidence, or recognition on the part of some of the people involved in the production of the Code, of the need for a training programme to enhance the understanding of the Code and its purpose and application. Indeed such training seems even more essential in the absence of any formal training or qualification programme that managers have to complete to practice which means that many will have had no background or understanding of ethical issues. Maybe the opportunity that has arisen to review the Code will provide the impetus to remedy this omission (see below).

The Code and prevailing values

There were serious inconsistencies between some of the behaviours advocated in the Code and those that prevailed in NHS management at the time it was issued. For example, members of the Code group referred to the fact that incentives and penalties for the way that managers act now were all related to the achievement or non-achievement of government targets in areas such as waiting list performance. Many, including members of the Code group, felt the Code should redress this imbalance by focussing managers' attention on what was best for patients in the local context. Some even believed that the Code should provide protection for managers against inappropriate central demands. This would seem to indicate that the values that needed to change were those being dictated by politicians and managers

at the centre because this was where the example was being set for those in the field.

On the other hand the fact that the Code was precipitated by failures in management behaviour in one organisation where the reasonable expectations of others, including patients, the public and other NHS staff, were not being met would also indicate that management behaviour in the field needed to change, too. So perhaps some re-appraisal of behaviour and values in the light of the Code is needed at all levels of NHS management if the Code is to be taken seriously. However, the 'set-aside' clause in the Code in the event of its provisions being inconsistent with central policy or other contractual obligations does not encourage one to believe that such a re-appraisal will take place. This is another reason for the prevailing apathy amongst managers about the Code.

The case study flagged up the concerns about the Code in relation to the changes being promoted for the NHS and the increasing emphasis on the creation of an NHS market. Here the view was that the concept of a cohesive code may not square with the changing roles of managers in different parts of the NHS or with those private sector providers who will increasingly be providing NHS services. Rightly or wrongly the impression that most managers have is that qualities such as openness and willingness to work in partnership will not be highly valued in the new world and that the Code will simply die on the vine without a substantial re-think. This danger has been recognised by the NHS Chief Executive who has commissioned a review of the Code and other codes of practice for the NHS so this may provide a real opportunity to explore how any revised code fits with the prevailing values. An essential precursor might be to clearly articulate what the prevailing organisational values are in an open and honest way as part of some collaborative dialogue with managers and others rather than creating another statement of ideals that is seen not to reflect reality.

Ethics and the NHS manager

As might have been expected the study revealed a keen interest from members of the Code group in the whole subject of ethics for NHS managers. Many saw the Code of Conduct as a vehicle for the expression of the ethics that they as individuals believed should underpin the practice of management, or at least a means for stimulating a debate about ethics within the management community and the wider NHS and the public. No less significant, though, was the interest that the managers in the field expressed in the subject of ethics as it affected them in their local situation. Despite the fact that generally they were uninspired by the Code of Conduct most recognised the need for some articulation of values that would be appropriate for them, most notably in the case study in the form of a local set of values and a code governing their local working arrangements with other NHS organisations. Similarly managers bemoaned the lack of opportunity for a real debate within the management community on the values underpinning the Code of Conduct. So this seems to indicate that there is a significant level of interest within the management community in debating and articulating their thoughts and ideas about the ethics of their activities.

However, what managers regarded as their framework of ethics seems to consist mainly of a set of personal morals that relates more to their background and life experience and their own local situation than to any set of derived values for NHS management as an entity. The question remains is this enough for those involved in the activity of managing such an important public service? If we say that something more is needed does the Code of Conduct meet that requirement? It seems that the public and those who work with managers have a right to expect that managers will carry out their responsibilities in the best interests of those whom they serve and that there should be a means of holding them to account for this. The Code of Conduct may be regarded as an attempt to meet this requirement.

However, would it be sufficient for managers to be governed by a combination of a personal ethic to be of service to others and a Code of Conduct that requires them to comply with a set of standards of to which they can be held to account? The evidence from this study is that there are many who believe

that this would be insufficient and that some set of derived values to guide managers is also needed. The problem with this view is how such an outcome can be achieved in a way that would secure the commitment of all managers and enhance the way they act and behave? In this respect the Code of Conduct seems to have been found wanting. This is not to say that such an initiative is not needed but that the way the Code was conceived and developed meant that it was always going to struggle to secure the voluntary commitment of managers that would be a key requirement for it to truly reflect their values.

Final Reflections

It has to be concluded that the Code of Conduct has had little impact so far and is not seen by managers as directly relevant to what they do. Similarly it has not provided the fist step in what some hoped would be recognition of NHS management as a profession in its own right. Indeed there can be little argument that NHS management cannot be recognised as a profession in the accepted definition of the term. However, throughout this study the integrity of those involved in NHS management and their motivation to carry out their work in a responsible and caring fashion has been a striking feature. I am drawn to the conclusion that NHS management is no less a noble and important responsibility because it is not recognised as a profession. The views of those managers who said that their motivation was to do their best for those that they served and the staff that they were responsible for managing should not be lost sight of in this regard because management in my view is essentially about facilitating the efforts of others towards an agreed, defined set of goals.

In terms of accountability for their actions and behaviour, it is arguable that something that specifies this in the form of a code might be useful to others so that it is clear what they might reasonably expect from NHS managers. Certainly the evidence from elsewhere is that such codes have been found to be needed to protect the organisation and those that it serves. Similarly, in the case of the Code of Conduct, there had been a significant failure in NHS

management that had brought the organisation into disrepute so some initiative was needed as a response to that.

However, the notion that the process adopted could also specify the values of NHS management was seriously flawed and inevitably has not succeeded in winning the commitment of managers. It has, however, flagged up the need for wider debate within the management community and the NHS about this issue, and the decision to review the Code in the light of concerns about its applicability to the 'new' NHS may provide the chance to stimulate such a debate. Fundamentally, what needs to be recognised by those involved in that review, as Wainwright and Pattison (2004) pointed out is that:

'Codes represent very imperfect, contradictory and unsatisfactory tools for value reinforcement and reproduction. For all that, they have real value. They form a necessary if not sufficient starting point for reflecting on values in professional practice.' Wainwright and Pattison, 2004, P121

Having concluded earlier that there is no obvious body or institution that would have the credibility with the management community, or, indeed perhaps the motivation, to lead such a process of reflection, and that any initiative driven by the Department of Health will always be viewed as being politically motivated, the question remains who can legitimately stimulate the sort of reflection on values that Wainwright and Pattison see as being the most constructive reason for having a code? In this vacuum of professional leadership for NHS managers, perhaps one pragmatic step that could be taken would be for those who recognise the importance of a real, informed debate about the values of NHS management to campaign for such a debate as part of the process for the revision of the Code of Conduct. Of course it has to be said that, on the evidence of this study, it may be questioned as to whether managers feel sufficiently strongly about these issues to challenge those above them, or to voice an opinion that may be out of step with their political masters. Certainly the fact that there has been little in the way of public criticism from managers about the current Code of Conduct, despite the fact that there seem to be many who view it as a partial document, seems to

reflect an unwillingness to 'rock the boat' that might of itself be part of the true prevailing values of NHS management. Others, however, could help to press for a real debate about values, such as those with academic interests in the subject and influence in the field of NHS management, and those authors and commentators who may be able, either directly or indirectly, to influence the 'opinion formers' involved in the review of the Code through the power of the pen.

Such an informed debate about the values of NHS management is, in my view, essential in understanding what might reasonably be expected from managers in terms of the way that they should act and behave. However, this study has also shown that articulating and working with values is not a straightforward process. There are often differing interpretations of seemingly definitive values, such as those relating to acting in the best interests of patients, and what constitutes acting with integrity. Often, also, articulated values seem to bear little relationship to 'lived' values, and sometimes in such cases, individuals either do not see any conflict or believe that some higher value provides the justification for the articulated values to be set aside. Also, the evidence of this study and the research quoted herein from elsewhere, shows that values change and have to be interpreted in the light of the situation. Nonetheless, for any real understanding to emerge about the values of NHS management these issues have to be grappled with, rather than set aside as being too difficult. Certainly for any Code of Conduct to emerge that purports to be an embodiment of the values of NHS management, this should be seen as a first step.

Finally, I am drawn to the conclusion that the Code of Conduct for NHS managers has not fulfilled its stated purpose, particularly in providing a guide for managers to help them in their decision-making. At a more modest level it has provided a statement of standards that arguably may help others to hold managers to account for how they act in certain situations, but even there it has its limitations. The positive hope is that the opportunity to review the Code will lead to improvements in the process, recognition of what Codes can and

can't achieve and a real improvement in engaging with managers in understanding the values of NHS management.

BIBLIOGRAPHY

Aristotle (1962), The Politics, Penguin Books, London

Bayles, M (1981), Professional Ethics, Wadsworth Publishing, Belmont, CA

Bell, J (1999), Doing your Research Project, Open University Press, Maidenhead, Berkshire

Bennion, A. R (1969), Professional Ethics, Charles Knight, London

Bentham, J (1970), An introduction to the Principles of Morals and Legislation, Criterium International Publishing Group, UK

Cadbury, A (1992), Report on the Committee on the Financial Aspects of Corporate Governance, Gee and Co Ltd, London

Calman, K (1994) The Profession of Medicine, British Medical Journal, 309; 1140 (29 October)

Committee on Standards in Public Life (1995), First Report of the Committee on Standards in Public Life, HMSO, London

Coote, A, Hunter, D.J (1996) New Agenda for Health, Public Policy for Research, London

Daniels, N, Sabin, and J.E (2002) Setting Limits Fairly: Can we Learn to Share Medical Resources? Oxford University Press, USA

Department of Health (1994), Code of Conduct; Code of Accountability, DoH, London

Department of Health (1995), Code of Practice on Openness in the NHS, DoH, London

Department of Health (1997), The New NHS: Modern, Dependable, DoH, Leeds

Department of Health (2001), Report of the Inquiry into Children's Heart Services at Bristol Royal Infirmary (The Kennedy Report), DoH, London

Department of Health (2002), The Code of Conduct for NHS Managers, DoH, London

Department of Health (2002), Managing for Excellence in the NHS, DoH, London

Department of Health and Social Security (1983), The NHS Management Inquiry (Griffiths Report), DHSS, London

Edgar, A (2004), Professionalisation and Aesthetic Values, in Pattison, S and Pill, R (ed), Values in Professional Practice, Radcliffe Publishing Ltd, Oxford

Friedson, E (1970), Profession of Medicine, Dodd Mead, New York

Freidson, E (2001), Professionalism: The Third Logic, Polity Press, Cambridge

General Medical Council, (1995), The Duties of a Doctor, GMC, London

General Medical Council, (1999) Management in Healthcare: the Role of Doctors, GMC, London

Harrison, S et al (1992), Just Managing – Power and Culture in the NHS, Macmillan, Basingstoke

Hunter, D.J (2001) The Appeal of Muddling Through Elegantly, in Healthcare Papers, Volume 2, number 2, pages 31-44

Hussey, T (1996), Nursing Ethics and Codes of Professional Conduct, in Nursing Ethics, Volume 3, number 3, pages 250 - 258

Institute of Directors (1995), Good practice for Directors – Criteria for NHS Boards, IoD, London

Institute of Healthcare Management (2001), The IHM Healthcare Management Code, IHM, London

Kant, I (1997), Critique of Pure Reason, Cambridge University Press, Cambridge

Loughlin, M (2002) Ethics, Management and Mythology, Radcliffe Medical Press, Oxford

McLean, S.A.M, Blair, A (2001) Medical Ethical Decisions in Healthcare, Highland Health Board, Scotland

MacIntyre, A (1981) After Virtue, Duckworth, London

Mill, J.S (1998), Utilitarianism, Oxford University Press, Oxford

NHS Confederation (2003), Medicine and Management – Improving Relations between Doctors and Managers, NHS Confederation, London

Nursing and Midwifery Council (2002), Code of Professional Conduct, NMC, London

O'Neill, O (2002), A Question of Trust, Cambridge University Press, Cambridge

Organisation for Economic Cooperation and Development (2000), Ethics Measures in OECD Countries, OECD Publishing, Paris

Parsons, T (1951), The Social System, Ashgate, Aldershot

Pattison, S (2001), Are Nursing Codes Ethical, in Nursing Ethics, volume 8, number 1, pages 5 -18

Pattison, S (2004), Understanding Values, in Pattison, S and Pill, R (ed), Values in Professional Practice, Radcliffe Publishing Ltd, Oxford

Pattison, S, Pill, R (2004), Professions and Values: a Dynamic Relationship, in Pattison, S and Pill, R (ed), Values in Professional Practice, Radcliffe Publishing Ltd, Oxford

Pill, R; Wainwright, P; McNamee, M; Pattison, S (2004), Understanding Professionals and Professions in the Context of Values, in Pattison, S and Pill, R (ed), Values in Professional Practice, Radcliffe Publishing Ltd, Oxford

Royal College of General Practitioners and the General Practice Committee of the General Medical Council (1999), Good Medical Practice for General Practitioners, GMC, London

Sommers, C.H, Sommers, F (1992), Vice and Virtue in Everyday Life: Introductory Readings in Ethics, Thomson Learning, USA

Tadd, V (1994), Professional Codes: An Exercise in Tokenism, in Nursing Ethics, volume 1, number 1, pages 15-23

The United Kingdom Central Council for Nursing, Midwifery, and Health Visiting (1992), The United Kingdom Central Council for Nursing, Midwifery and Health Visiting Code of Professional Conduct, UKCC, London

Wainwright.P; Pattison.S (2004), What can we expect of Professional Codes of Conduct, Practice and Ethics, in Pattison.S and Pill.R (ed), Values in Professional Practice, Radcliffe Publishing Ltd, Oxford

Wall, A (1989), Ethics and the Health Services Manager, King Edward's Hospital Fund for London, London

Wall, A (2004), Is Health Services Management a Profession?, in Pattison, S and Pill, R (ed), Values in Professional Practice, Radcliffe Publishing Ltd, Oxford

White, D (16 March 2000), Ethical policy can bear fruit, Daily Telegraph

Appendix 1

NHS

Code of Conduct for NHS Managers

October 2002

Introduction

1. As part of the response to the Kennedy Report, the attached *Code of Conduct for NHS Managers* has been produced by a Working Group chaired by Ken Jarrold CBE.

2. The Code sets out the core standards of conduct expected of NHS managers. It will serve two purposes:

- to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make.
- to reassure the public that these important decisions are being made against a background of professional standards and accountability.

3. The environment in which the Code will operate is a complex one. NHS managers have very important jobs to do and work in a very public and demanding environment. The management of the NHS calls for difficult decisions and complicated choices. The interests of individual patients have to be balanced with the interests of groups of patients and of the community as a whole. The interests of patients and staff do not always coincide. Managerial and clinical imperatives do not always suggest the same priorities. A balance has to be maintained between national and local priorities.

4. The Code should apply to all managers and should be incorporated in the contracts of senior managers at the earliest possible opportunity. A document on implementation is attached.

NIGEL CRISP 9 October 2002
NHS Chief Executive

Code of Conduct for NHS Managers

As an NHS manager, I will observe the following principles:

- make the care and safety of patients my first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for my own work and the proper performance of the people I manage;
- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;
- take responsibility for my own learning and development.

This means in particular that:

1 I will:

- respect patient confidentiality;
- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public and patients;
- be guided by the interests of the patients while ensuring a safe working environment;
- act to protect patients from risk by putting into practice appropriate support and disciplinary procedures for staff; and
- seek to ensure that anyone with a genuine concern is treated reasonably and fairly.

2 I will respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies. In my capacity as a senior manager within the NHS I will seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin. I will also seek to ensure that:

- the public are properly informed and are able to influence services;
- patients are involved in and informed about their own care, their

experience is valued, and they are involved in decisions;

- relatives and carers are, with the informed consent of patients, involved in the care of patients;

- partners in other agencies are invited to make their contribution to improving health and health services; and

- NHS staff are:

  - valued as colleagues;

  - properly informed about the management of the NHS;

  - given appropriate opportunities to take part in decision making.

  - given all reasonable protection from harassment and bullying;

  - provided with a safe working environment;

  - helped to maintain and improve their knowledge and skills and achieve their potential; and

  - helped to achieve a reasonable balance between their working and personal lives.

3 I will be honest and will act with integrity and probity at all times. I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer.

I will seek to ensure that:

- the best interests of the public and patients/clients are upheld in decision-making and that decisions are not improperly influenced by gifts or inducements;

- NHS resources are protected from fraud and corruption and that any incident of this kind is reported to the NHS Counter Fraud Services;

- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded; and

- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear.

4 I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:

- the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;

- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and

- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery.

I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers and the Department of Health in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets.

For the avoidance of doubt, nothing in paragraphs two to four of this Code requires or authorises an NHS manager to whom this Code applies to:

- make, commit or knowingly allow to be made any unlawful disclosure;

- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law.

If there is any conflict between the above duties and obligations and this Code, the former shall prevail.

5 I will show my commitment to working as a team by working to create an environment in which:

- teams of frontline staff are able to work together in the best interests of patients;

- leadership is encouraged and developed at all levels and in all staff groups; and

- the NHS plays its full part in community development.

6 I will take responsibility for my own learning and development. I will seek to:

- take full advantage of the opportunities provided;

- keep up to date with best practice; and

- share my learning and development with others.

Department of Health October 2002

IMPLEMENTING THE CODE

1. The Code should be seen in a wider context that NHS managers must follow the 'Nolan Principles on Conduct in Public Life', the 'Corporate Governance Codes of Conduct and Accountability', the 'Standards of Business Conduct', the 'Code of Practice on Openness in the NHS' and standards of good employment practice.

2 In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code.

In order to maintain consistent standards, NHS bodies need to consider suitable measures to ensure that managers who are not their employees but who

> (i) manage their staff or services; *or*
> (ii) manage units which are primarily providing services to their Patients

also observe the Code.

3 It is important to respect both the rights and responsibilities of managers. To help managers to carry out the requirements of the Code, employers must provide reasonable learning and development opportunities and seek to establish and maintain an organisational culture that values the role of managers. NHS managers have the right to be:

- treated with respect and not be unlawfully discriminated against for any reason;
- given clear, achievable targets;
- judged consistently and fairly through appraisal;
- given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development; and
- reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives.

Breaching the Code

4 Alleged breaches of the Code of Conduct should be promptly considered and fairly and reasonably investigated. Individuals must be held to account for their own performance, responsibilities and conduct where employers form a reasonable and genuinely held judgement that the allegations have foundation. Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problems. Activity, the purpose of which is to learn from and prevent breaches of the Code, needs to look at their wider causes.

5 Local employers should decide whether to investigate alleged breaches informally or under the terms of local disciplinary procedures. It is essential however that both forms of investigation should be, and be seen to be, reasonable, fair and impartial. If Chief Executives or Directors are to be investigated, the employing authority should use individuals who are employed elsewhere to conduct the investigation. The NHS Confederation, the Institute of Healthcare Management and the Healthcare Financial Management Association are among the organisations who maintain lists of people who are willing to undertake such a role.

Application of Code

6 This Code codifies and articulates certain important contractual obligations that apply to everyone holding management positions. These include Chief Executives and Directors who as part of their duties are personally accountable for achieving high quality patient care. The Department of Health will in the next few months issue a proposed new framework of pay and contractual arrangements for the most senior NHS managers. Under this framework the job evaluation scheme being developed as part of the 'Agenda for Change' negotiations is likely to be used as the basis for identifying which other managerial posts (in addition to Chief Executives and Directors) should be automatically covered by the Code. The new framework will also specify compliance with the Code as one of the core contractual provisions that should apply to all senior managers.

7 For all posts at Chief Executive/Director level and all other posts identified as in paragraph 6 above, acting consistently with the Code of Conduct for NHS Managers Directions 2002, employers should:

- include the Code in new employment contracts;
- incorporate the Code into the employment contracts of existing postholders at the earliest practicable opportunity.

Action

8 Employers are asked to:

(i) incorporate the Code into the employment contracts of Chief Executives and Directors at the earliest practicable opportunity *and* include the Code in the employment contracts of new appointments to that group;

(ii) identify any other senior managerial posts, i.e. with levels of responsibility and accountability similar to those of Director-level posts, to which they consider the Code should apply. (The new framework for pay and contractual arrangements will help more tightly define this group in due course.)

(iii) investigate alleged breaches of the Code by those to whom the Code applies promptly and reasonably as at paragraphs four to five;

(iv) provide a supportive environment to managers (see paragraph three

above).

October 2002

NATIONAL HEALTH SERVICE ACT 1977
NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990
The Code of Conduct for NHS Managers Directions 2002

The Secretary of State for Health, in exercise of the powers conferred by section 17(**a**),
paragraph 10(1) of Schedule 5(b) and paragraph 8(3) of Schedule 5A(c) to the National
Health Service Act 1977, and paragraph 16(5) of Schedule 2 to the National Health Service and Community Care Act 1990(**b**), hereby gives the following Directions:

Application, commencement, interpretation
1.
(1) These Directions apply to all NHS bodies in England and shall come into force on 9
October 2002.
(2) These Directions shall be referred to as The Code of Conduct for NHS Managers Directions 2002.
(3) In these Directions 'NHS bodies' means:
(i) Strategic Health Authorities
(ii) Special Health Authorities
(iii) NHS Trusts
(iv) Primary Care Trusts

Implementation of Code of Conduct for NHS Managers
2. NHS bodies shall take all reasonable steps to comply with the requirements set out in the
Code of Conduct for NHS Managers appended to these Directions.

Effect of Direction 2
3. The fact of compliance or non-compliance with Direction 2 shall in itself have no effect on
the validity or enforceability of a contract entered into by an NHS body to which these Directions apply.

Signed by authority of the Secretary of State for Health

M G Sturges

4 October 2002 Department of Health

(**a**) 1977 c. 49. Section 17 was substituted by section 12(1) of the Health Act 1999 (c.8) and was amended by Schedule 5, Part
1, paragraph 5(1) and (3), to the Health and Social Care Act 2001 (c.15) and by Schedule 1, paragraph 7 to the NHS Reform
and Health Care Professions Act 2002 (c.17).
(**b**) Paragraph 10(1) of Schedule 5(b) and paragraph 8(3) of Schedule 5A(c) to the National Health Service Act 1977 (1977
c.49), and paragraph 16(5) of Schedule 2 to the National Health Service and Community Care Act 1990 were amended by
section 6 of the Health and Social Care Act 2001 (c.15).

Working Group Members

Ken Jarrold CBE
Chief Executive
County Durham and Tees Strategic Health Authority

Dr Gill Morgan
Chief Executive
NHS Confederation

Stuart Marples
Chief Executive
Institute of Healthcare Management

Professor Jenny Simpson OBE
Chief Executive
British Association of Medical Managers

John Flook
Chairman
Healthcare Financial Management Association

Penny Humphris
Director
NHS Leadership Centre

Appendix 2

OUTLINE OF MY RESEARCH TOPIC FOR PARTICIPANTS

Introduction

This appendix includes a transcript of the questions that I used as a framework for the interviews with members of the Code of Conduct Working Group, and managers in the field. It also includes my opening statement to participants to assure them that the research would be carried out responsibly and that aspects such as confidentiality would be safeguarded.

I had earlier given participants a summary of my area of interest at the time that I sought their agreement to participate. This summary is included earlier in this thesis as an abstract.

Questions for use in semi-structured interviews with members of the Working Group for the Code of Conduct for NHS Managers

1. Who was the client for the Code and what was the brief for your task?
2. Was the Code modelled on any existing codes, or inspired by them?
3. Why do you think a Code was necessary?
4. What do you hope that the Code will achieve?
5. What advice did you take on how to formulate the Code?
6. In what circumstances do you think it will be particularly important for managers to consult the Code?
7. In your view is the Code aimed particularly at guiding the way that managers act or setting out the qualities that are required in managers?
8. Do you believe that management behaviour is significantly out of tune with the Code currently and if so in what way and why?
9. What difference do you think it would make to managers' practices and decisions if there were no Code?

10. How has the Code been received, a) by the client, and, b) by managers?
11. What training has/is being provided for managers in how to use the Code?
12. Do you believe that incorporating the Code into the employment contracts of Chief Executives and Directors will be beneficial and if so why?
13. Is the Code being evaluated, if so how and by whom?
14. What impact do you think the Code has had since its introduction last year?
15. How would you like the Code to be viewed by managers in 3 years from now?
16. What do you see as its limitations?
17. To your knowledge have there been any instances of breaches of the Code over the past year and, if so, what has been the outcome?
18. Have you had any occasion to refer to it in your own work? If so can you give a specific example of decision-making where adherence to all or part of the Code was important in determining your approach?
19. Do you have any further comments to make?

Statement for use at start of Interviews

'I am very grateful to you for sparing the time for this interview. I am using a framework of standard questions to try to get reliable and comparable results but please feel free not to answer any of the questions if you wish. I will also invite you to make any additional comments that you may want to make because the questions may not cover everything that you want to say and those comments would help to add to the richness of the information.

Also I want to assure you that I will do everything I can to respect confidentiality of the information you give me. I am not proposing to send participants a draft copy of my thesis, but, if I were to quote you by name in my thesis I would only do so after seeking your permission. I will, as far as

possible, use such information either in summarised form, or by anonymising it.

If at any stage, either during or after this interview, you wish to withdraw, or to amend any of your answers let me know and I will not use them. I will also check with you at the end of the interview whether there is anything that you would not wish me to use.'

Appendix 3

LIST OF INTERVIEWEES FROM THE WORKING GROUP FOR THE CODE OF CONDUCT FOR NHS MANAGERS

Ken Jarrold CBE
Chief Executive
County Durham and Tees Strategic Health Authority

Dame Gill Morgan
Chief Executive
NHS Confederation

Stuart Marples
Chief Executive (then)
Institute of Healthcare Management

Professor Jenny Simpson
Chief Executive
British association of Medical Managers

Appendix 4

QUESTIONNAIRE FOR PCT BOARD MEMBERS ON THE CONDUCT AND ETHICS OF A MAJOR SERVICE CHANGE PROPOSAL

Name:

Role:

Questions:

1. What were your own personal hopes and aspirations in proposing/supporting these changes?
2. What were the most important factors for you in ensuring that the PCTs position/decision was soundly based?
3. Do you believe that these were properly taken into account?
4. Does the PCT have a set of ethical principles that are applied to decisions of this type?
5. Were they useful in this case?
6. How far was external guidance useful?
7. Are you familiar with the Code of Conduct for NHS Managers?
8. Was it used or referred to in this case?
9. What were the known facts on which the decision was based? (NB. To establish how far the organisation sought to make an informed decision)
10. Who were the key parties involved and what were their desired outcomes? (To assess to what extent the organisation was committed to take these into account)
11. How far do you believe that the key parties would view the PCT's position/decision to be fair?
12. Would you be happy for the PCT's position/decision on this issue to be used as a precedent for other similar issues in the future?

13. How open was the process of arriving at the PCT's position/decision on this issue and were there any aspects that you would be unhappy to see divulged to others?
14. Has the PCT done/will it do anything to accommodate the consequences of the decision on those who are significantly affected by it?
15. Were your own values or principles compromised at any stage in the process and what did you see as the main pressures that you were under?
16. In hindsight, do you think that anything should have been done differently and, if so, what and by whom?